

1
M-246 69 6501 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 6501

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 24, 1969		Hour 7:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year June 24, 1969		Hour 7:45 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1602	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 8-11-31		10. AGE (In years last birthday) 37		E. STREET AND NUMBER 1409 Edmondson Avenue			
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Johnnie Boone			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Grace Stuckey			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 247-62-6239		18. INFORMANT Grace S. Burch		ADDRESS 1409 Edmondson Avenue	
19. <i>E968X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 6-22-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Head injury				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) stairs		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1409 Edmondson Avenue		16-02	
22D. TIME OF INJURY (APPROX.) 6-21-69		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Injured during altercation			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 24, 1969							
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6-26-69		24C. NAME of CEMETERY or CREMATORY Springhill Cemetery		24D. LOCATION (City, town, or county) (State) Bishopville, South Carolina	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 Monroe Street	

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HERMAN WILLIAMS

2. DATE OF DEATH

Known ☒ Estimated ☐

Month Day Year

Hour

6 23 69 9:00 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital D.O.A.

3. DATE PRONOUNCED DEAD

Month Day Year

Hour

June 23, 1969 9:00 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

3-9-1934

10. AGE (In years lost birthday)

35

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1413 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Isaac Williams

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosetta MC Neill

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mary Williams 2119 South St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Fatty alteration of the liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 23, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/27/69

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore Md.

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 26 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

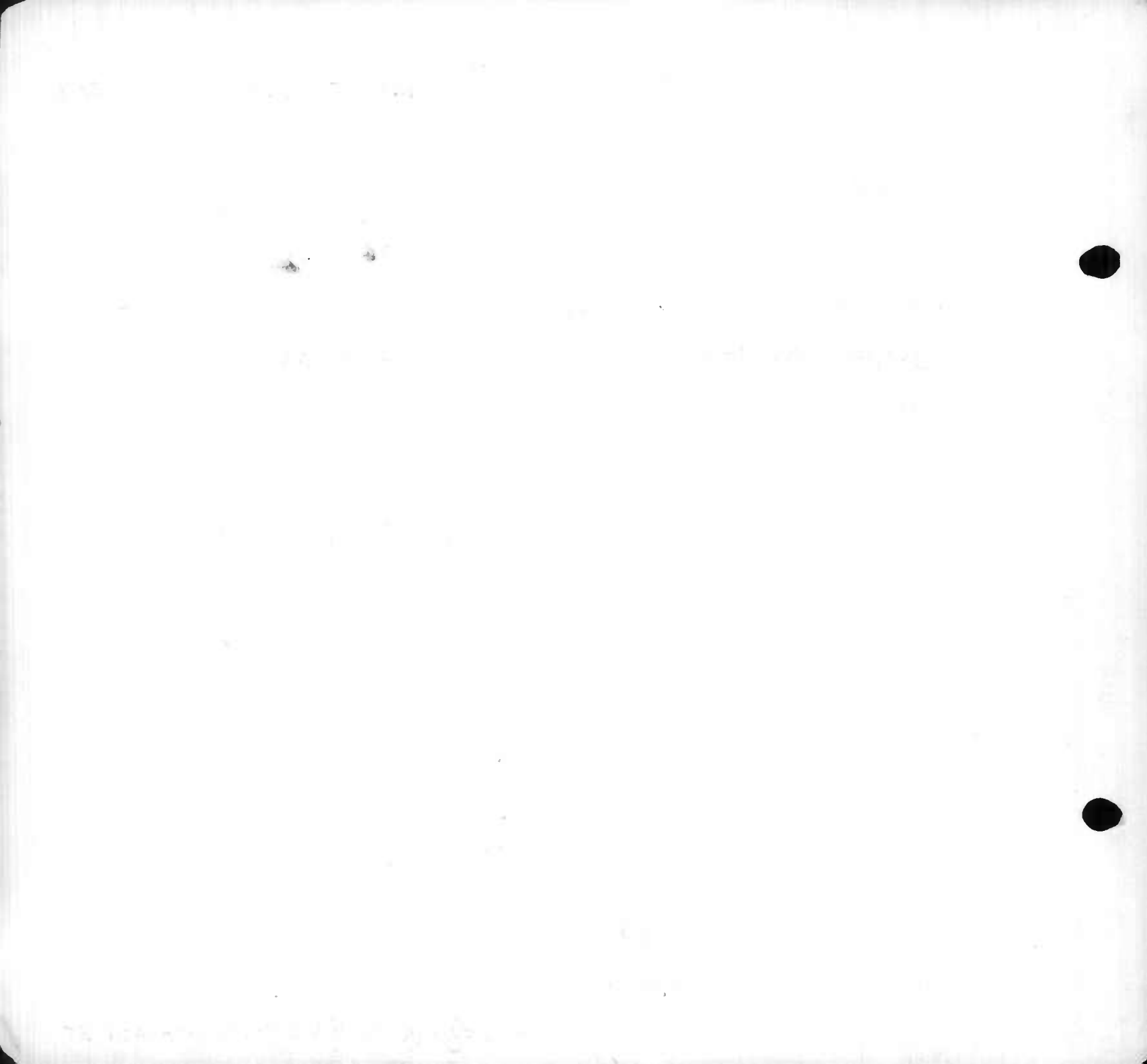
25C. FUNERAL DIRECTOR

William Phillips 1727 N. Mount St.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 6503		69 6503		69 6503	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) NOWAK Mr. JAMES.			2. DATE AND HOUR OF DEATH 6.27.1969 3:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital, 100 N Broadway, Baltimore 21231.			A. STATE MD B. COUNTY 202		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 215 S. Ann St. (31)		
5. SEX Male	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8.11.1896	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoremen Retired			10B. KIND OF BUSINESS OR INDUSTRY STEVEDORING		11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph NOWAK		
14. MOTHER'S MAIDEN NAME P. CATHERINE			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217 07 2910			17. INFORMANT ADDRESS Adam Nowak 237 S. Ann St. (31)		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gram - ve septicaemia 3 weeks					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary tract infection Diabetes mellitus					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6.1.1969 to 6.27.1969 that (I) (we) last saw the deceased alive on 6.27.1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Mesbah Uddin Dowlah MD			23B. DATE SIGNED 6/27/69		23C. PHYSICIAN'S NAME (Type) MESBAH UD DOWLA - MD
23D. ADDRESS CHURCH HOME AND HOSPITAL			23E. DATE REC'D BY HEALTH DEPT. JUN 30 1969		
23F. NAME OF REGISTRAR James E. Taylor, M.D.			23G. FUNERAL DIRECTOR ADDRESS George R. Weber 705 SOUTH ANN ST		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					

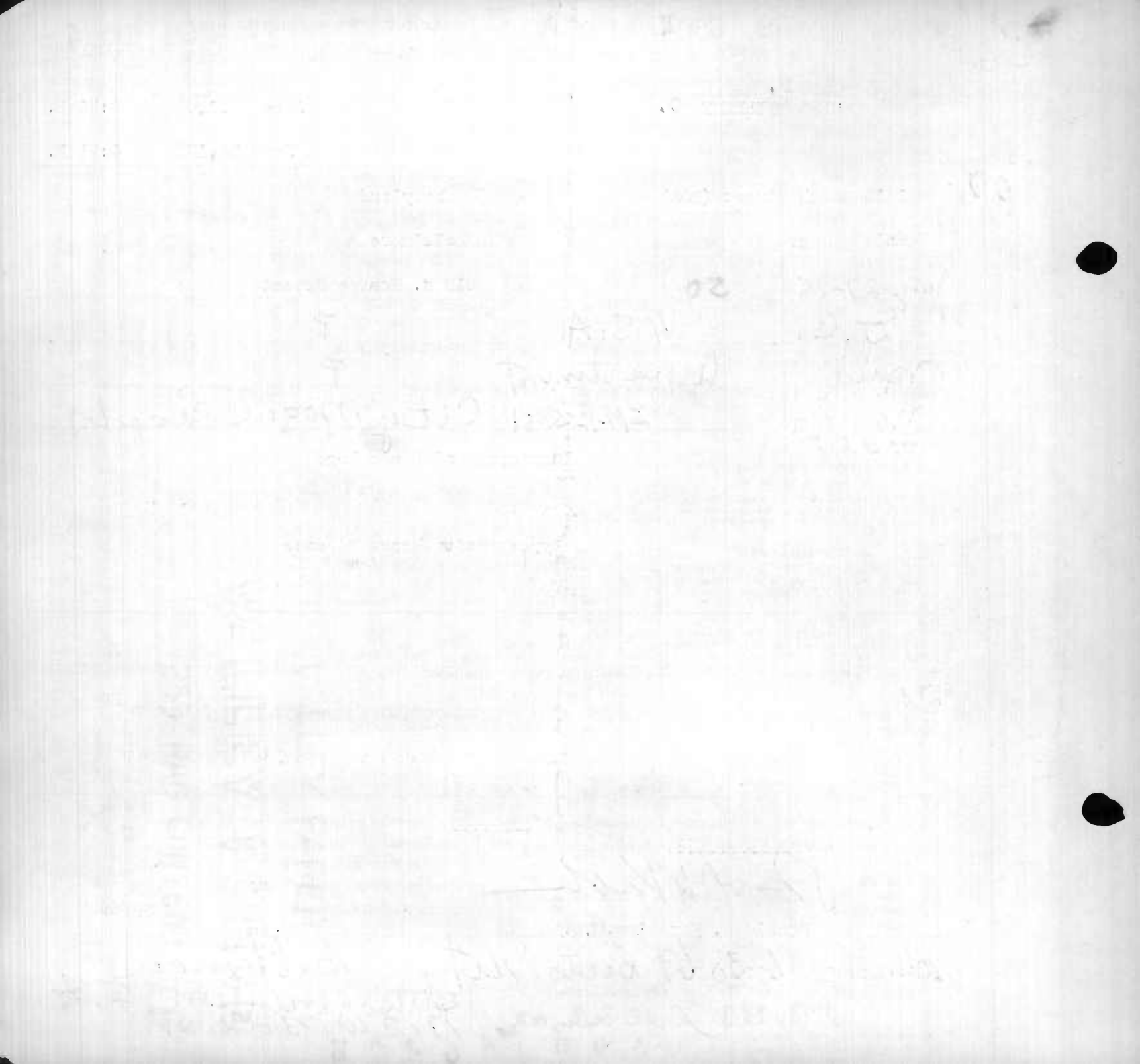


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

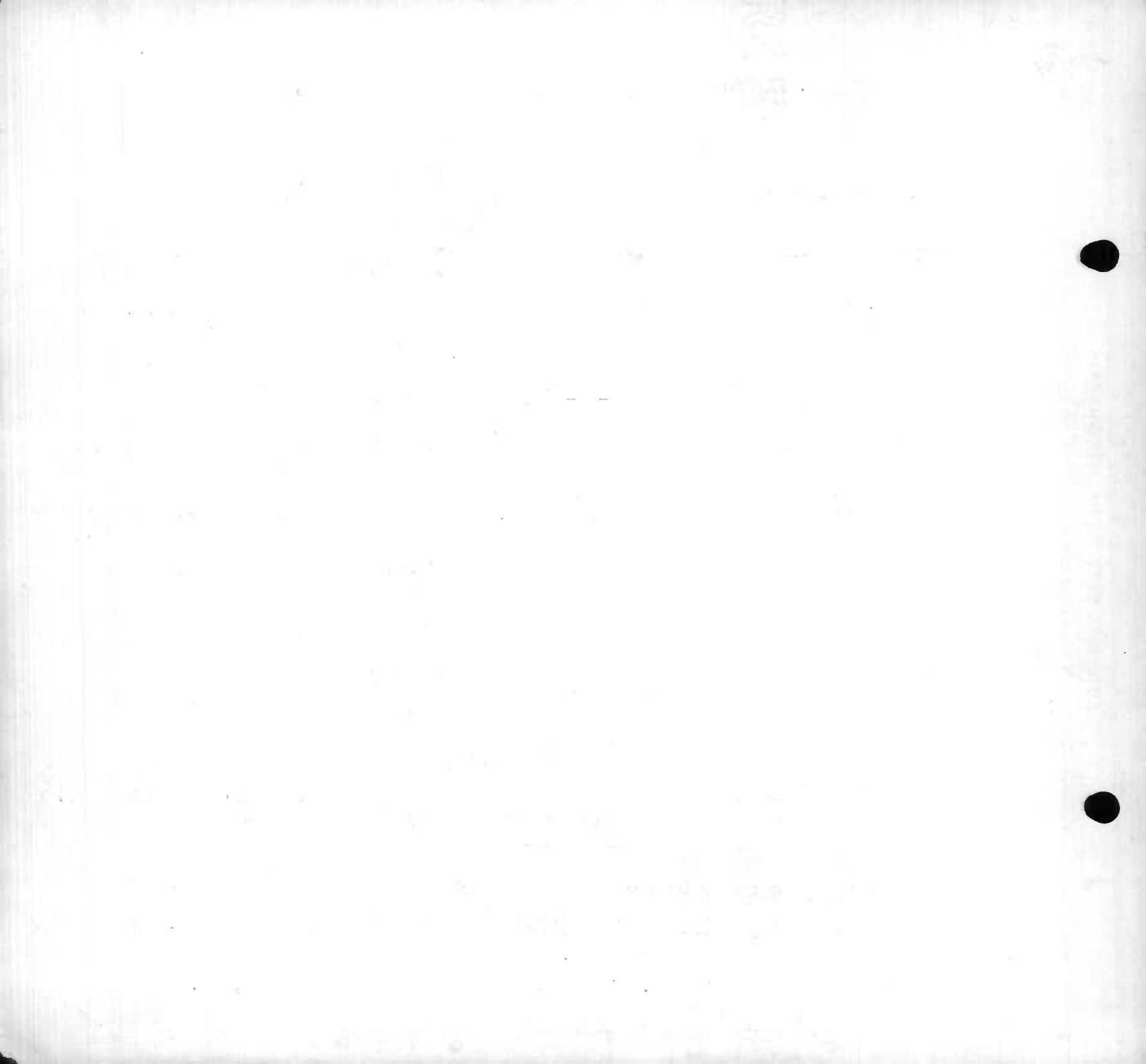
BIRTH NO.

1. NAME OF DECEASED (Type or Print) THELMA PINKNEY C.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 24, 1969		Hour 4:21 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1018 Booth Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 24, 1969		Hour 4:21 P. M.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH July-27-18		10. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME P		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	
15. MOTHER'S MAIDEN NAME P		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 2-17-12-5387	
18. INFORMANT City Mosque Records		19. CAUSE OF DEATH Intracerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Hypertensive Heart Disease DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/25/69	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-69		24C. NAME OF CEMETERY or CREMATORY Balto. Nat.	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Faib, M.D.	
25C. FUNERAL DIRECTOR Stinson & Wilson, F. H.		25D. ADDRESS 1913 W. Balto. St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6505	
BIRTH NO. 69 6505				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Daisy L. Fleming			2. DATE AND HOUR OF DEATH June 26, 1969 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2788		
FULL NAME OF HOSPITAL OR INSTITUTION 3526 Hayward Avenue 21215			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 10/31/1876
13. FATHER'S NAME Winfield Shaull			14. MOTHER'S MAIDEN NAME Mary (Lewis)		9. AGE (In years last birthday) 92
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-10-4888 D		11. BIRTHPLACE (State or foreign country) West Virginia
17. INFORMANT Helen Smith			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Broncho-pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). none			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 1 19 67 to June 26 19 67 , that (I) (we) last saw the deceased alive on June 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Manuel Levin			23B. DATE SIGNED 6/28/69		23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/30/69		24C. NAME OF CEMETERY or CREMATORY Mt. Olive Cemetery
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969			25B. NAME OF REGISTRAR E. Taylor, M.D.		25C. FUNERAL DIRECTOR Loring Myers
24D. LOCATION (City, town, or county) Randallstown, Md. 21133			25D. ADDRESS 8728 Liberty Road 21133		



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69 6506 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6506

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) M. JOHN SPARROW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1705 St. Paul Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 25, 1969 3:15 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1205	
9. DATE OF BIRTH Nov 25, 1900		10. AGE (In years last birthday) 68 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis J. Sparrow		14. MOTHER'S MAIDEN NAME Iva Robinson	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		18. SOCIAL SECURITY NO. 218-14-1535	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 412.4 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) _____ (B) _____ (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
25. TIME OF INJURY (APPROX.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		28. HOW DID INJURY OCCUR?	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED June 26, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69	
24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Walters Funeral Home	
25C. FUNERAL DIRECTOR Pratt & Stricker		25D. ADDRESS 6407 Sts.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 6507		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 6507	
1. NAME OF DECEASED (Type or Print) Concetta Fioravante				2. DATE AND HOUR OF DEATH 24 June 1969 11:35 p.m.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 4024 Raleigh Rd.	
5. SEX W F		6. RACE Fern		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-90		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buttonhole maker				10B. KIND OF BUSINESS OR INDUSTRY Cohen & Goldman		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Guilano Nicholas Desantis				14. MOTHER'S MAIDEN NAME Mary Ann Delguida					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-05-3594		17. INFORMANT Mrs. Mary Carson, dght. above			
18. 427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE cerebral hypoxia DUE TO, OR AS A CONSEQUENCE OF: (B) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (C) multiple rib fracture, diabetes mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs. 20 hrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 10 days from revision many yrs.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 10 days from revision		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from 13 June 1969 to 24 June 1969 that (I) (we) last saw the deceased alive on 24 June 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert A. Norum M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 24 June 69	
23C. PHYSICIAN'S NAME (Type) Robert A. Norum, M.D.				23D. ADDRESS Johns Hopkins Hospital, Baltimore, Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/69		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Schidunek Funeral Home, Inc.				ADDRESS 63331 Brehms Lane	

7/1/69 - Cardiac Arrest - 4/14/69
med exam. office via phone
re.

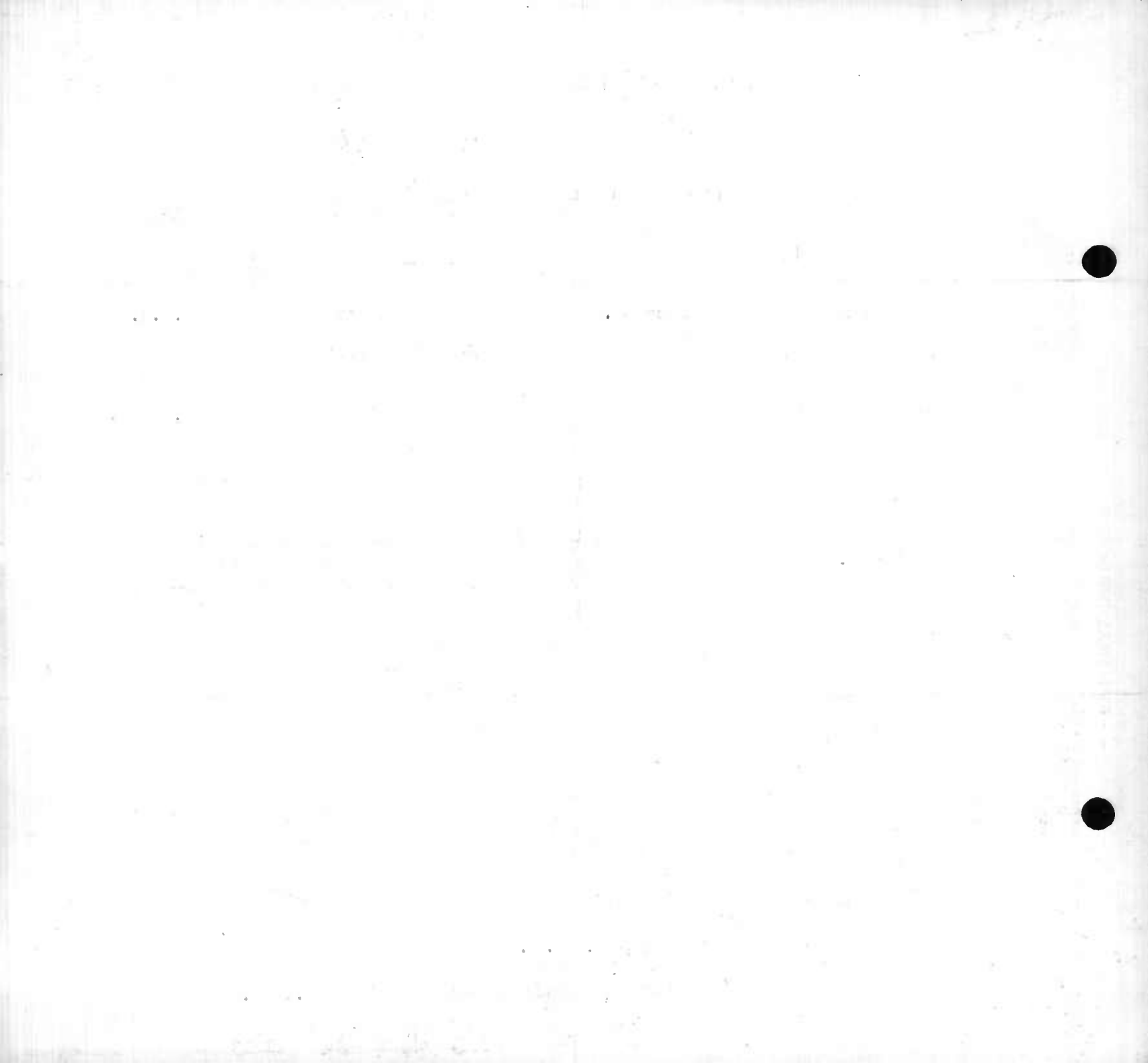
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6508

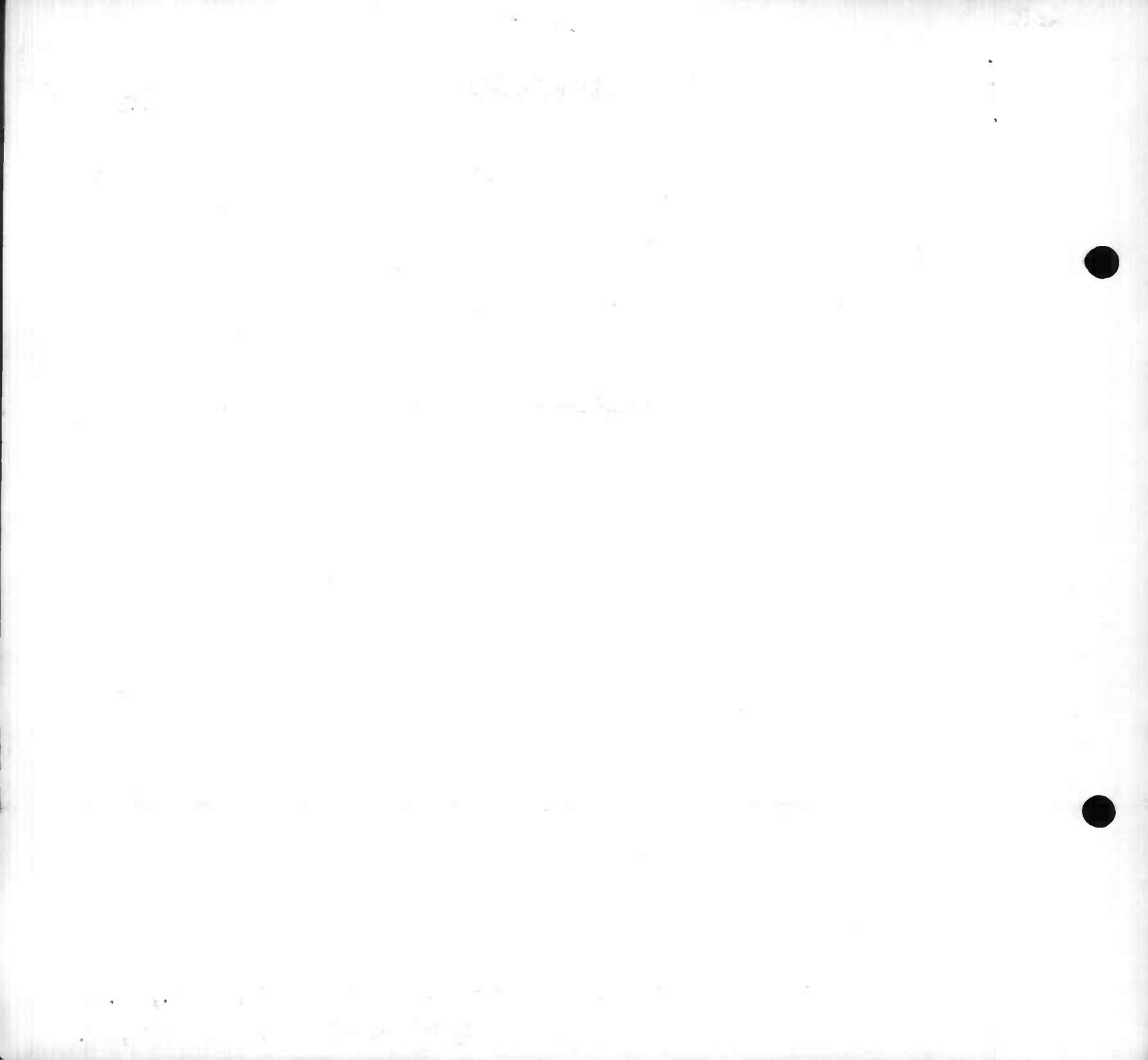
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles THOMAS ROBBINS		6-26-69 2:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				5127 WRIGHT AVENUE 21205	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
MALE	WHITE			10-23-16	52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician		Armco Co.		Baltimore, Maryland	U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
THOMAS ROBBINS				JESSIE SNYDER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes WWII		215 18 7955		Anna Robbins (nee Morrison), wife, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				? Cardiac arrhythmia 10-15m	
				(B) Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF:	
				(C) W/o sept. ventric. aneurysm	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ASCVD	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 6-14 1969 to 6-26 1969 that (1) (we) last saw the deceased alive on 6-26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Leonard Rosoff, Jr. M.D. DEGREE				6-26-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
LEONARD ROSOFF, JR. M.D.				601 No. Broadway, JPH	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6/30/69		Baltimore National Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 30 1969		Wm E. Jaber M.D.		Schimunek Funeral Home 3331 Rehms Lane 21213	



FUNERAL DIRECTOR: IMPORTANT

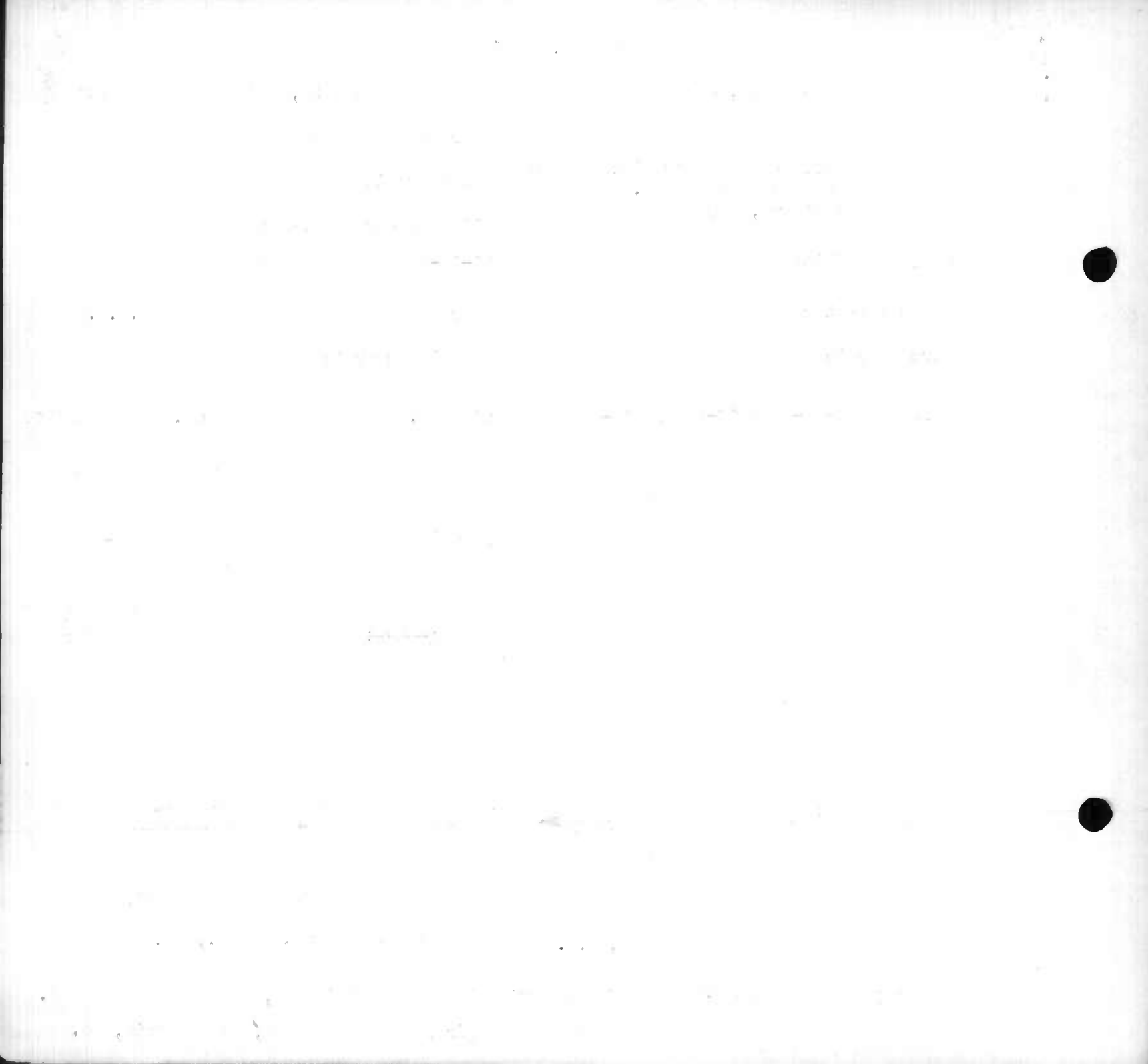
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6509	
BIRTH NO. 69 6509					
1. NAME OF DECEASED (Type or Print) Wilbur B. Warfield			2. DATE AND HOUR OF DEATH 6-25-69 6:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundel Co.		
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital			C. CITY OR TOWN Glen Burnie, Md.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER Box 693, Route 2		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-02	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent		10B. KIND OF BUSINESS OR INDUSTRY Pennsylvania RR		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME EDGAR Warfield.			14. MOTHER'S MAIDEN NAME ELIA WATTS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-7854		17. INFORMANT As Chant	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal Insufficiency (B) ASEVD & CHF DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6-9 19 69 to 6-25 19 69 that (I) (we) last saw the deceased alive on 6-25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE U. Bangkum			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) U. BANGKUM
23D. ADDRESS			23E. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 28 June 69		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR J. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25D. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

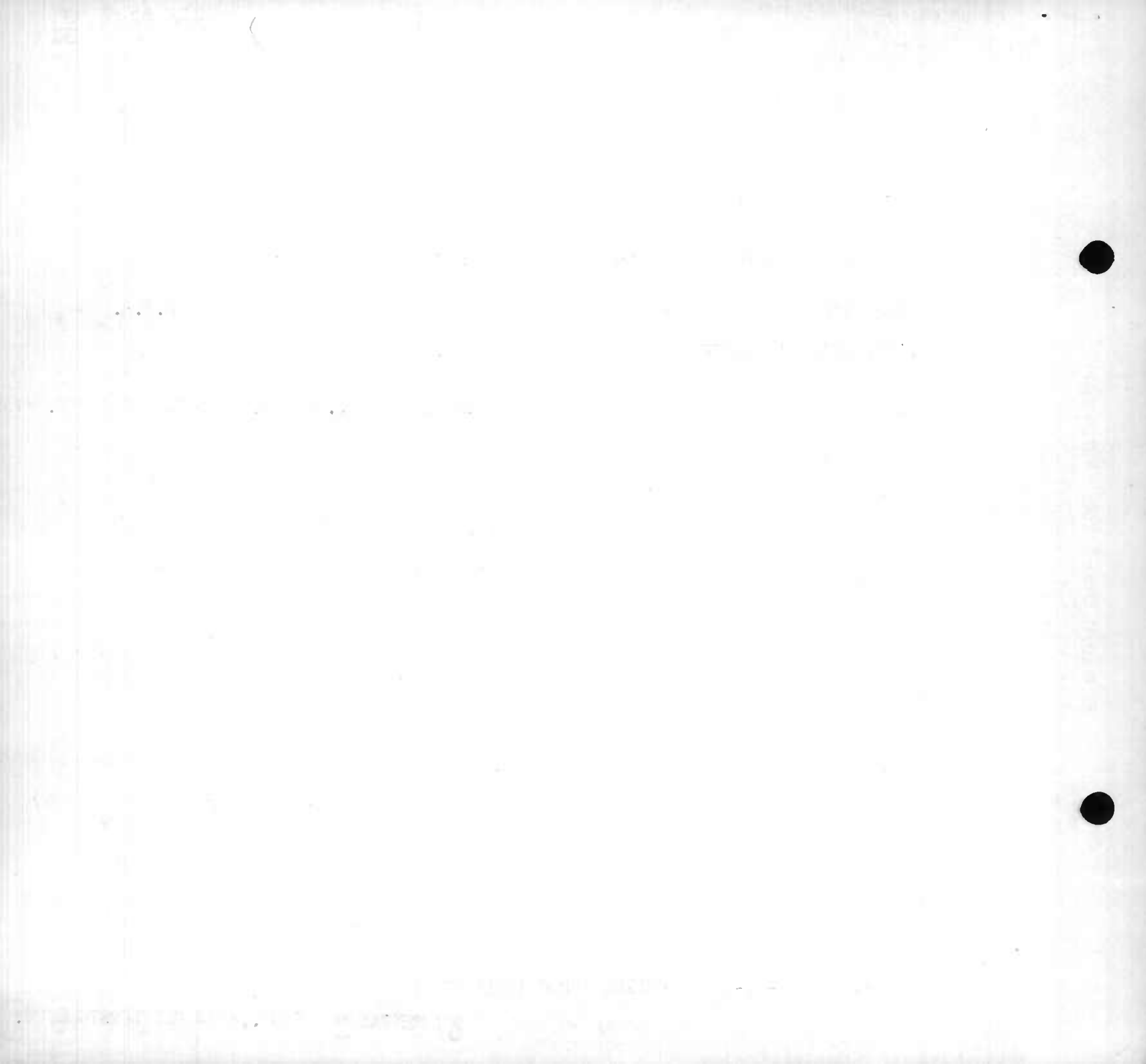
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 6510		CERTIFICATE OF DEATH		69 6510	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARRICK, JAMES WILMER		June 26, 1969 5:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Glen Burnie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Male		White		8. DATE OF BIRTH 11-15-15	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 53	
Dozer operator				11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Percy Carrick		14. MOTHER'S MAIDEN NAME Nellie McCormick		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 12-29-43 to 12-17-45		218-036541		Records VA Hosp. 3900 Loch Raven Blvd. Balto Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Suspected acute myocardial infarction minutes	
		(B) Chronic bronchitis & chronic obstructive DUE TO, OR AS A CONSEQUENCE OF:		airway disease 2-3 yrs	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Alcoholic cirrhosis		at least 6 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from June 23 19 69 to June 26 19 69 that (X) (we) last saw the deceased alive on June 26 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.					
23A. SIGNATURE Marcia C. Schmidt M.D.				23B. DATE SIGNED June 26, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MARCIA C SCHMIDT, M.D.				3900 Loch Raven Blvd. Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		30 June 69		Baltimore National	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 30 1969		Robert E. Haber, R.D.		Kirby Funeral Home, Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500 69 6511		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-5352 6511	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) COHEN, ZARA. &		2. DATE AND HOUR OF DEATH 6-26-69 4²⁰ M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN Hospital of Md		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 15-10		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH XXXXXX		9. AGE (In years last birthday) 86		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LATAVIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISAAC ZELIG LEHNHOFF		14. MOTHER'S MAIDEN NAME MALCA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS MISS LILLIAN Z. COHEN, 4003 FERNHILL AVE. #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 410.9 I Myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary disease (B) DUE TO, OR AS A CONSEQUENCE OF: Atrial Fibrillation (C) Cerebral embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Chronic	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-14 1969 to 6-26 1969 , that (I) (we) last saw the deceased alive on 6-26 4²⁰ AM 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sy Huh		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) SOUNG. YOON HUH MD		23D. ADDRESS LUTHERAN Hospital of Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-69		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR John E. G. B. M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL BEVINS & BROS., 6010 REISTERSTOWN RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

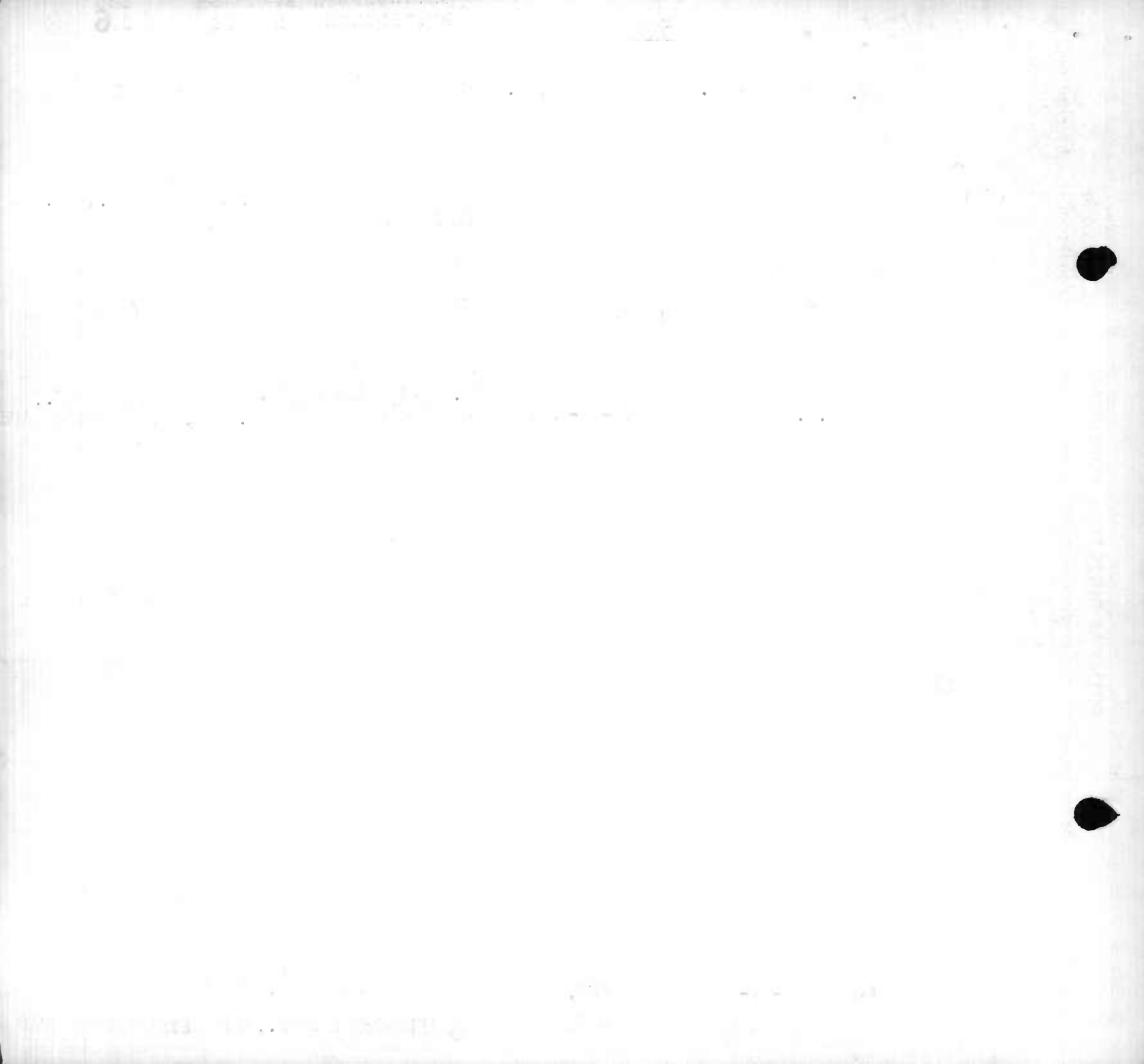
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 6512	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) FRED KALINER		2. DATE AND HOUR OF DEATH JUNE 25 1969 11:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND 38 HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE & COUNTY MARYLAND 2755 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6505 DEANCROFT RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/09	9. AGE (In years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANDISE RETAIL
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANDISE RETAIL		10B. KIND OF BUSINESS OR INDUSTRY MERCHANDISE RETAIL		11. BIRTHPLACE (State or foreign country) PHILADELPHIA PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MAURICE KALINER			
14. MOTHER'S MAIDEN NAME SARA H. FARBER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ETHEL KALINER, 6505 DEANCROFT ROAD #21209			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEAR	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DISSEMINATED THYROID CANCER				(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 6 19 69 to June 25 19 69 that (I) (we) last saw the deceased alive on June 25 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles M. Harrison MD				23B. DATE SIGNED June 25, 1969	
23C. PHYSICIAN'S NAME (Type) CHARLES M. HARRISON MD				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-69		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	
24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
L-525 69 6513		CERTIFICATE OF DEATH		69 SP6513	
1. NAME OF DECEASED (Type or Print) DR. Albert S. Loewenson, JR.		2. DATE AND HOUR OF DEATH June-26-69 4:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 1301			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb-18-1922		9. AGE (in years last birthday) 47		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10B. KIND OF BUSINESS OR INDUSTRY DENTAL		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Loewenson (Dec.)		14. MOTHER'S MAIDEN NAME Carolyn Hanline	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service yes W.W. II ARMY		16. SOCIAL SECURITY NO. 216-28-6611		17. INFORMANT MRS. CARLYN LOEWENSON, TEMPLE GARDEN APTS., APT. 803, 2601 MADISON AVENUE	
18. 2381 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Third ventricular tumor ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Communicating hydrocephalus Sec #1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4-7-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydrocephalus		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June-25-69 to June-26-69 that (I) (we) last saw the deceased alive on June-26-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jorge R. Ordóñez		23B. DATE SIGNED June-26-69		23C. PHYSICIAN'S NAME (Type) Jorge R. Ordóñez	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-69		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE, HEBREW	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969			
25B. NAME OF REGISTRAR J. E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		25D. ADDRESS 6010 REISTERSTOWN ROAD	



53-96

djs

C-526

69

6514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69

6514

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Adelina Concor dia

2. DATE AND HOUR OF DEATH

June 26 69 9.50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Balt. City Hosp. Balto 29, MD.

1940 EASTERN AVE. BALTO. MD. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND BALTIMORE C

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

7231 BRIDGEWOOD DRIVE 21224

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

HOUSEWIFE

ITALY

ITALY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

21224

BCH: RECORDS 1940 EASTERN AVE. BALTO. MD.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

CVA

3 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Pneumonia

2 wks.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At ☐
WorkNot While ☐
At Work22. I certify that (I) (this hospital) attended the deceased from May 23, 69 19 69 to June 26 19 69.
that (I) (we) last saw the deceased alive on June 26 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Born Umanian

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

June 26, 69

23C. PHYSICIAN'S
NAME (Type)

Born Umanian

DEGREE

BALTIMORE CITY HOSPITALS

1940 EASTERN AVE. BALTO. MD. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

6/30/69

HOLY REDEEMER

BALTO. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

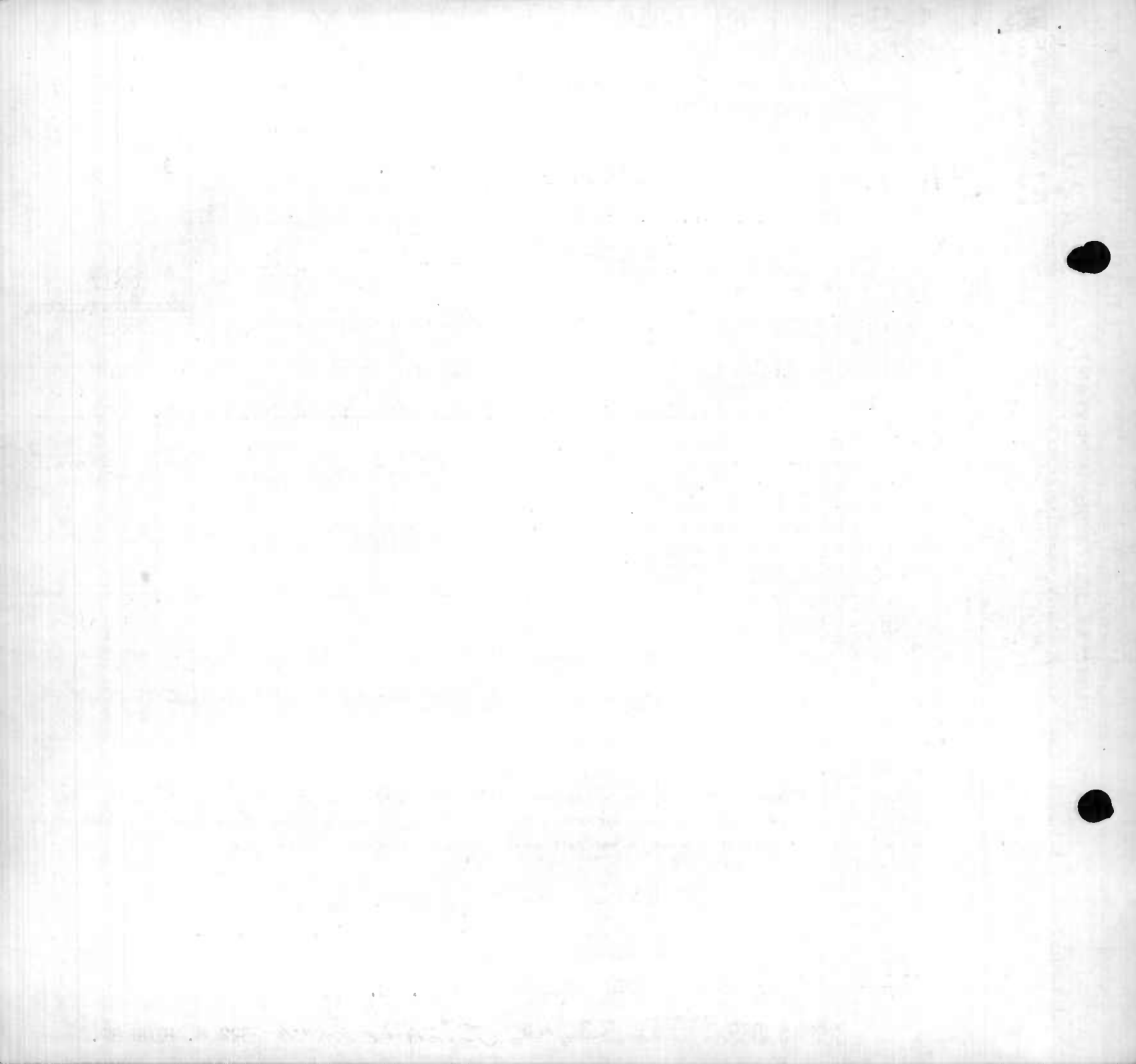
JUN 30 1969

E. Faber, M.D.

322 S. HIGH ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

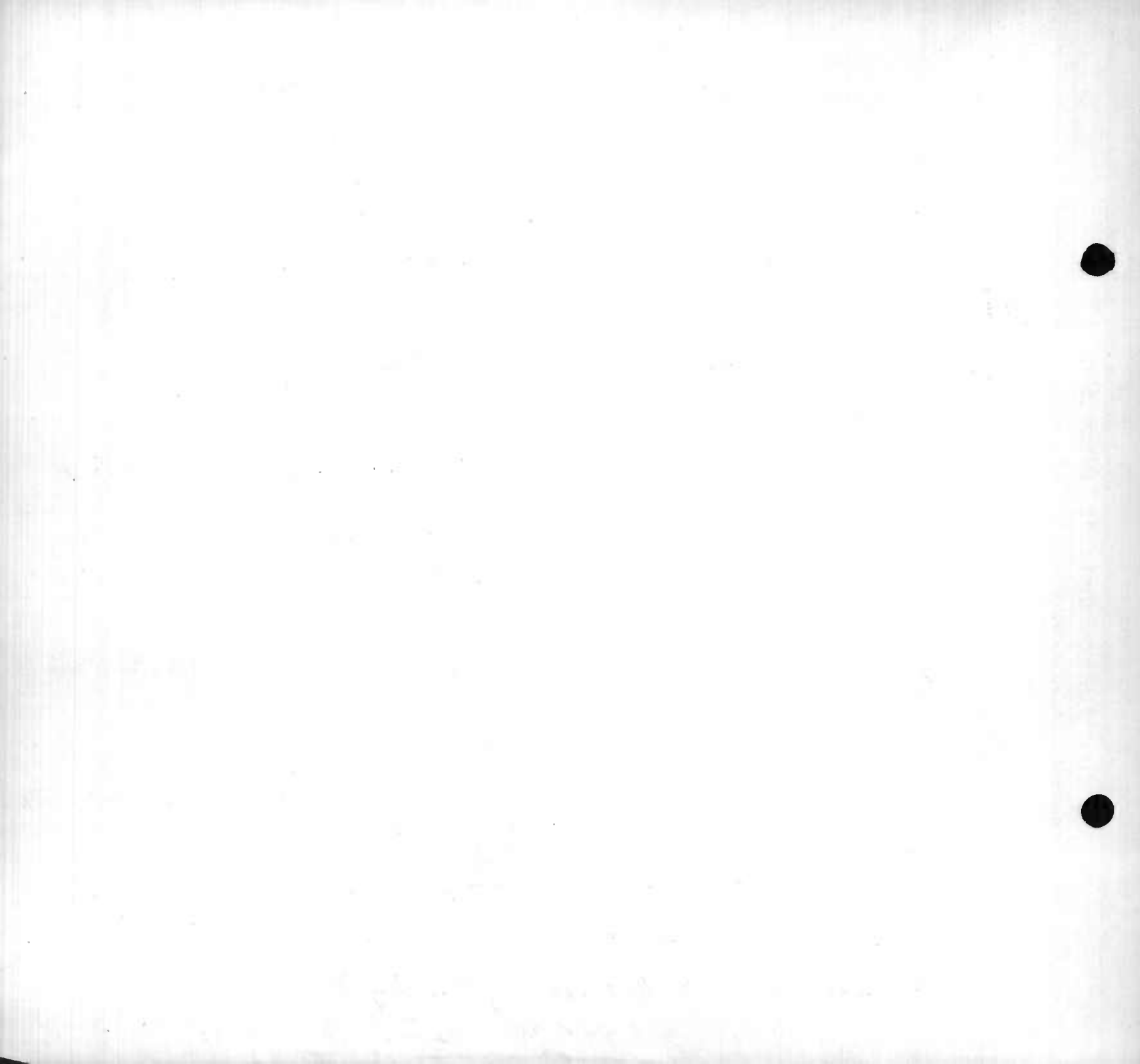


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
 REG. NO. **89 6515**

BIRTH NO. 69 6515		1. NAME OF DECEASED (Type or Print) SMITH, Agnes		2. DATE AND HOUR OF DEATH June 24, 1969 8:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Ctr.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3504 Reisterstown Road 15-12			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-10	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 412.2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Relative cerebral stroke (B) Hypertensive C.V. disease (C) atherosclerosis, gen		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/69 year year	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/4 1969 to 6/24 1969 , that (I) (we) last saw the deceased alive on 6/24 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6/25/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MAEHT MD				23D. ADDRESS 2 E Real St Baltimore 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-27-69		24C. NAME OF CEMETERY or CREMATORY Brooklyn	
24D. LOCATION (City, town, or county) MD		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS 605 N. P. R. 21220 North			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. 69 6516				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6516			
1. NAME OF DECEASED (Type or Print) <u>Celia Dreyer</u>						2. DATE AND HOUR OF DEATH <u>June 26, 1969</u> <u>2 P</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Friedlers Guest House</u> <u>2449 Shirley Avenue</u>						A. STATE <u>MD</u> C. CITY OR TOWN <u>Balto</u> E. STREET AND NUMBER <u>2449 Shirley Ave</u>					
5. SEX <u>F</u>		6. RACE <u>M</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 6, 1929</u>		9. AGE (If years lost birthday) <u>39</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Russia</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Isaac</u>						14. MOTHER'S MAIDEN NAME <u>Rae</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Freder Potts</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.3 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH <u>Cerebral Thrombosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>none</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 years</u>	
MEDICAL CERTIFICATION											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>none</u>											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1966</u> to <u>June 26, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jun 26, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Manuel Levin</u>								23B. DATE SIGNED <u>6/26/69</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>	
23D. ADDRESS <u>6101 PARK HIGHS AVE BALTO-15 MD</u>				23E. DEGREE							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <u>6/27/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mushkon Israel</u>				24D. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1969</u>				25B. NAME OF REGISTRAR <u>Indus E. Feller, M.D.</u>				25C. FUNERAL DIRECTOR <u>Sylvan S. S. & Son, Inc</u>			
25D. ADDRESS <u>9610 Reisterstown Rd</u>											

1880

1881

1882

1883

1884

1885

1886

1887

1888

1889

1890

1891

P-456

69

6517

BALTIMORE CITY HEALTH DEPARTMENT

69

6517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RALPH G. PLUMMER Jr.

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

312 W. Camden St., Rm. 219

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 23, 1969

2:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Queen Anne's

67-00

C. CITY OR TOWN

Churchville

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

8-17-1919

10. AGE (In years
last birthday)

58 49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Ralph G. Plummer Sr.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Margaret Daskieles

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Margaret Plummer

Church Hill Md

19.

571.8 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty liver
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 24, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

6/24/69

24C. NAME of CEMETERY or CREMATORY

Mt. Oliver

24D. LOCATION

(City, town, or county)

(State)

Balto.,

Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

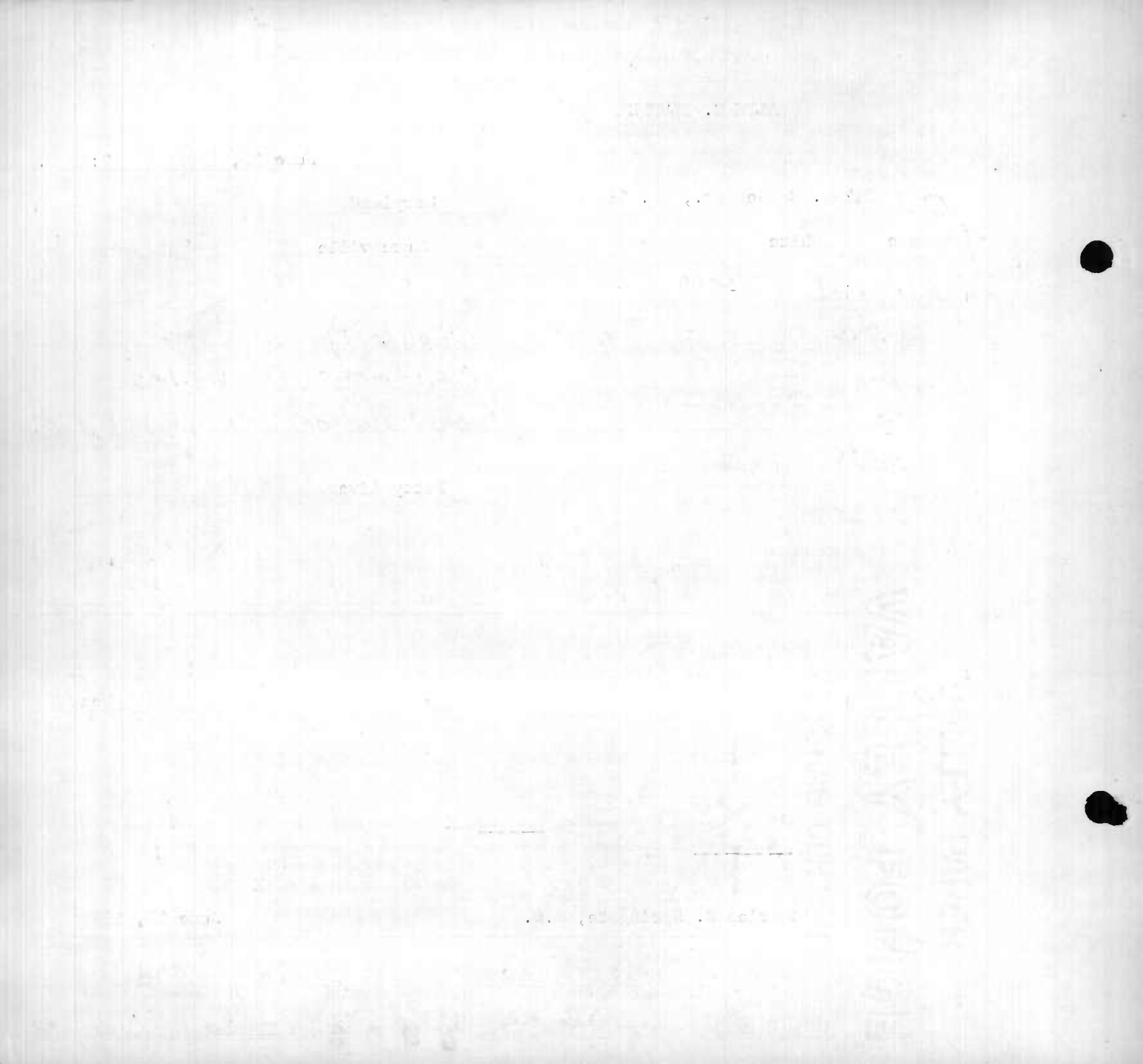
25C. FUNERAL DIRECTOR

ADDRESS

JUN 30 1969

James E. Fisher, M.D.

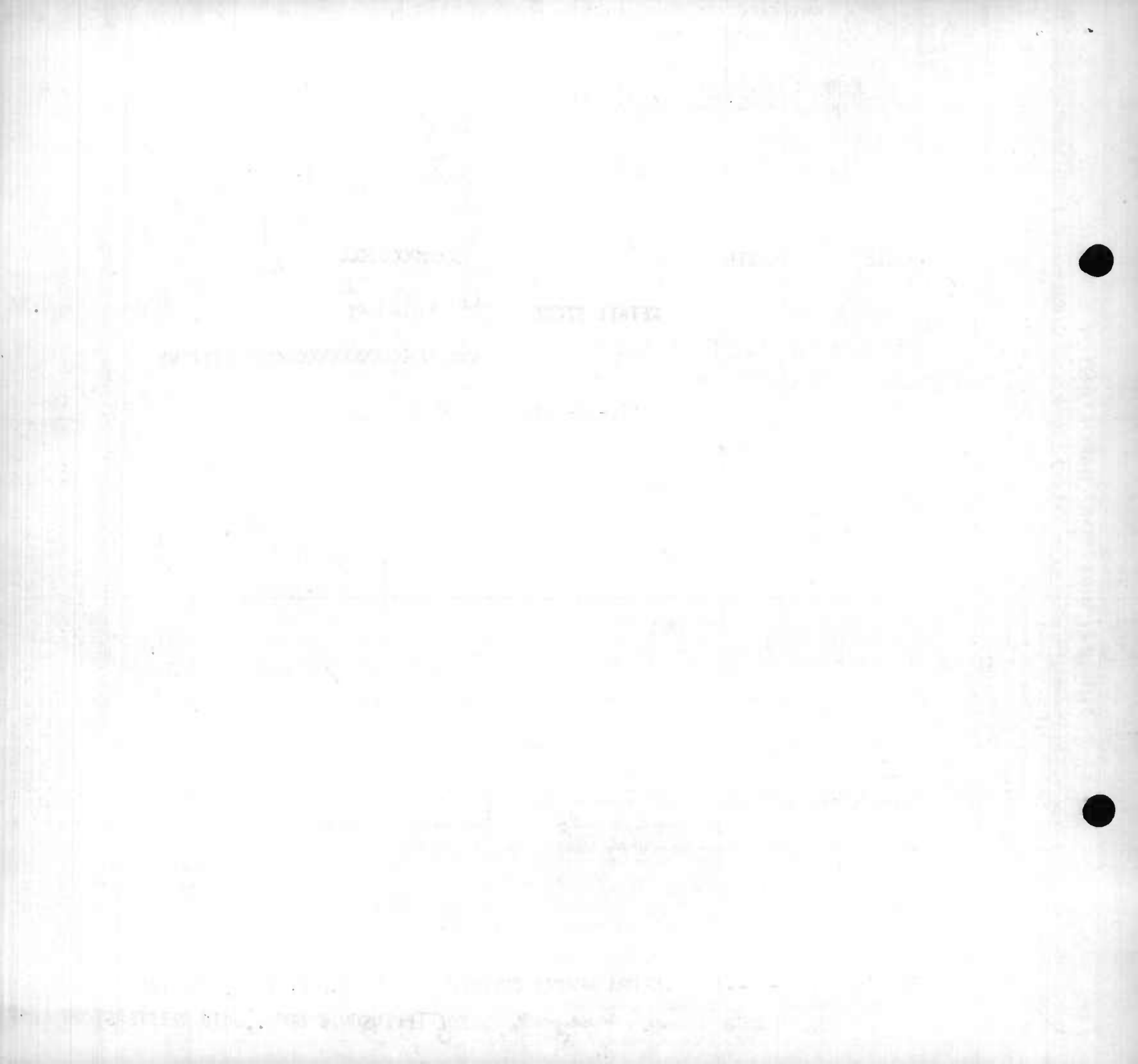
Wm. J. Fickner & Sons, Balto., Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

G-314		69 6518		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6518	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) XXX Gottfeld, William J.			
2. DATE AND HOUR OF DEATH 6-25-69				11-25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2747			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hosp. 35				C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2713 E. North Pk. Way							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY RETAIL STORE		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? America U.S.A.	
13. FATHER'S NAME FELIX GOTTFELD				14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX PHILIPINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-32-9514		17. INFORMANT ADDRESS Charlotte Gottfeld 2713 North Pk way			
18. CAUSE OF DEATH							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Oedema Ca. Prostratae (B) DUE TO, OR AS A CONSEQUENCE OF: metastasis (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-21-1969 to 6-25-1969, that (I) (we) last saw the deceased alive on 6-25-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Mustahud Dowlah MD				23B. DATE SIGNED 6/24/69		23C. PHYSICIAN'S NAME (Type) NIESBAH UD - DOWLA MD	
23D. ADDRESS CHEVRA AHAVAS CHESSED				23E. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-26-69		24C. NAME of CEMETERY or CREMATORY CHEVRA AHAVAS CHESSED		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR J. E. S. S.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6519	
BIRTH NO. H-155		69 6519		CERTIFICATE OF DEATH X	
1. NAME OF DECEASED (Type or Print) FRANK HOFFMAN			2. DATE AND HOUR OF DEATH JUNE 24, 1969 11:24 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER X 8910 MAPLEBROOK ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 8, 1919	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY PACKAGE LIQUOR		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME HARRY HOFFMAN			14. MOTHER'S MAIDEN NAME KATIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. RAE HOFFMAN, 8910 MAPLEBROOK ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease and previous Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: Severe Crohn's Disease		(C) 9 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 2 1960 to 6-24-1969 , that (I) (we) last saw the deceased alive on 6-3-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
26A. SIGNATURE <i>Joseph Deckelbaum</i>				23B. DATE SIGNED 6-25-69	
23C. PHYSICIAN'S NAME (Type) JOSEPH DECKELBAUM				23D. ADDRESS 3502 W. ROGERS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-26-69		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO	
24D. LOCATION BALTIMORE, MARYLAND		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR <i>Joseph E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25D. ADDRESS		25E. (City, town, or county) (State)			

These specimens being
temporarily deposited
in the Department of
Agriculture and
Forestry, Ottawa,
Ontario.

W. J. V. S.

6-3-10

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6-3-10

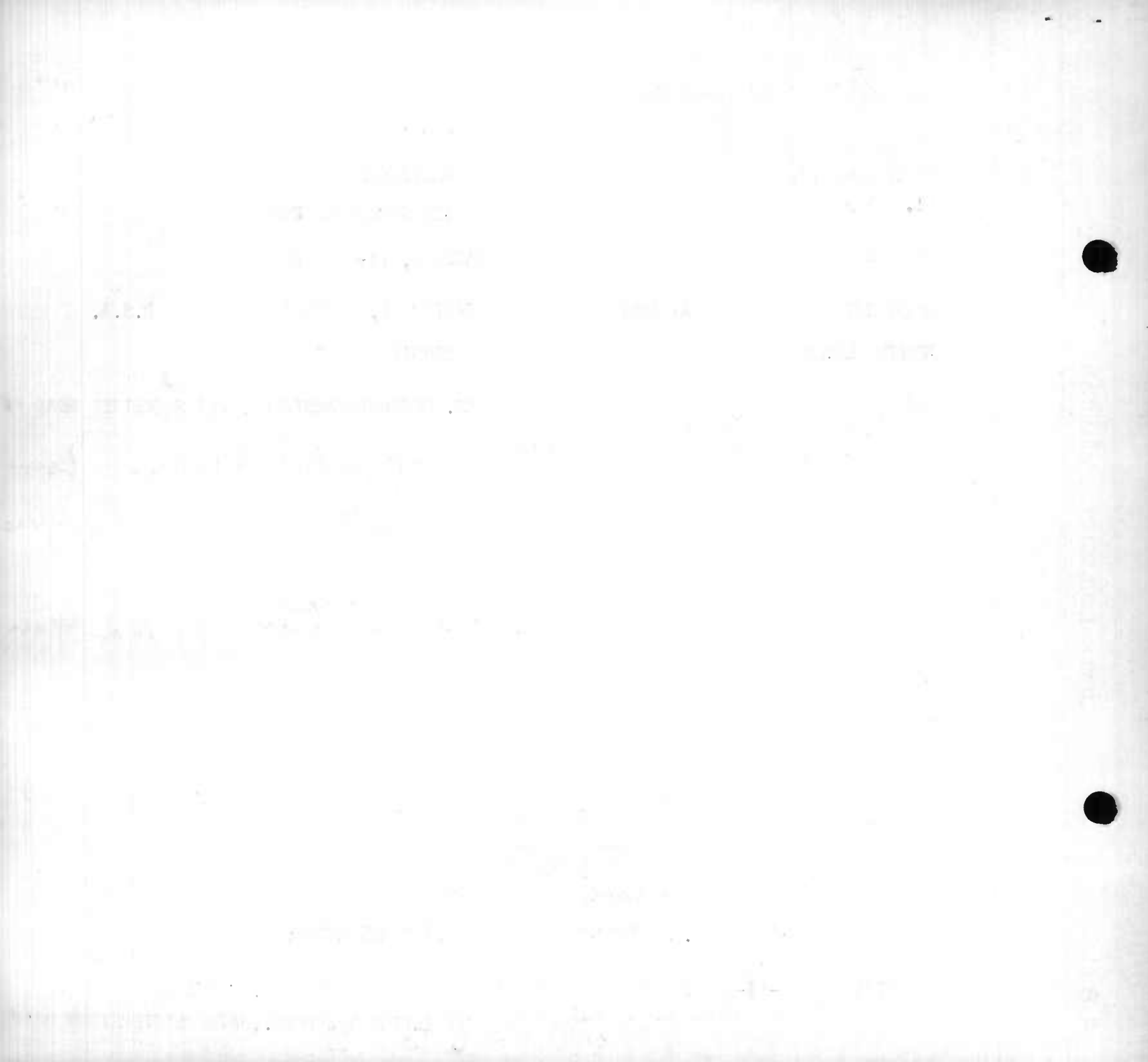
6-3-10

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. L-150				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6520	
1. NAME OF DECEASED (Type or Print) Levin, Jennie				2. DATE AND HOUR OF DEATH 6-25-69 2³⁰ AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 421 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 820 SMOKETREE ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 5, 1896		9. AGE (In years last birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH BERKOW				14. MOTHER'S MAIDEN NAME MINNIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. HERBERT DANSICKER, 820 SMOKETREE ROAD #8			
18. 410.94 1250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Qew D				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Qew D (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. 410.94 1250.9 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour Many years Many years			
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 52 to 6-25 19 69 , that (I) was last saw the deceased alive on 6-23 19 69 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.							
23A. SIGNATURE Stanley R Steinback				23B. DATE SIGNED 6-25-69		23C. PHYSICIAN'S NAME (Type) STANLEY R. STEINBACK	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 6-26-69		24C. NAME OF CEMETERY or CREMATORY MOSES MONTIFILORE	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				25A. DATE REC'D BY HEALTH DEPT. JUN 26 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



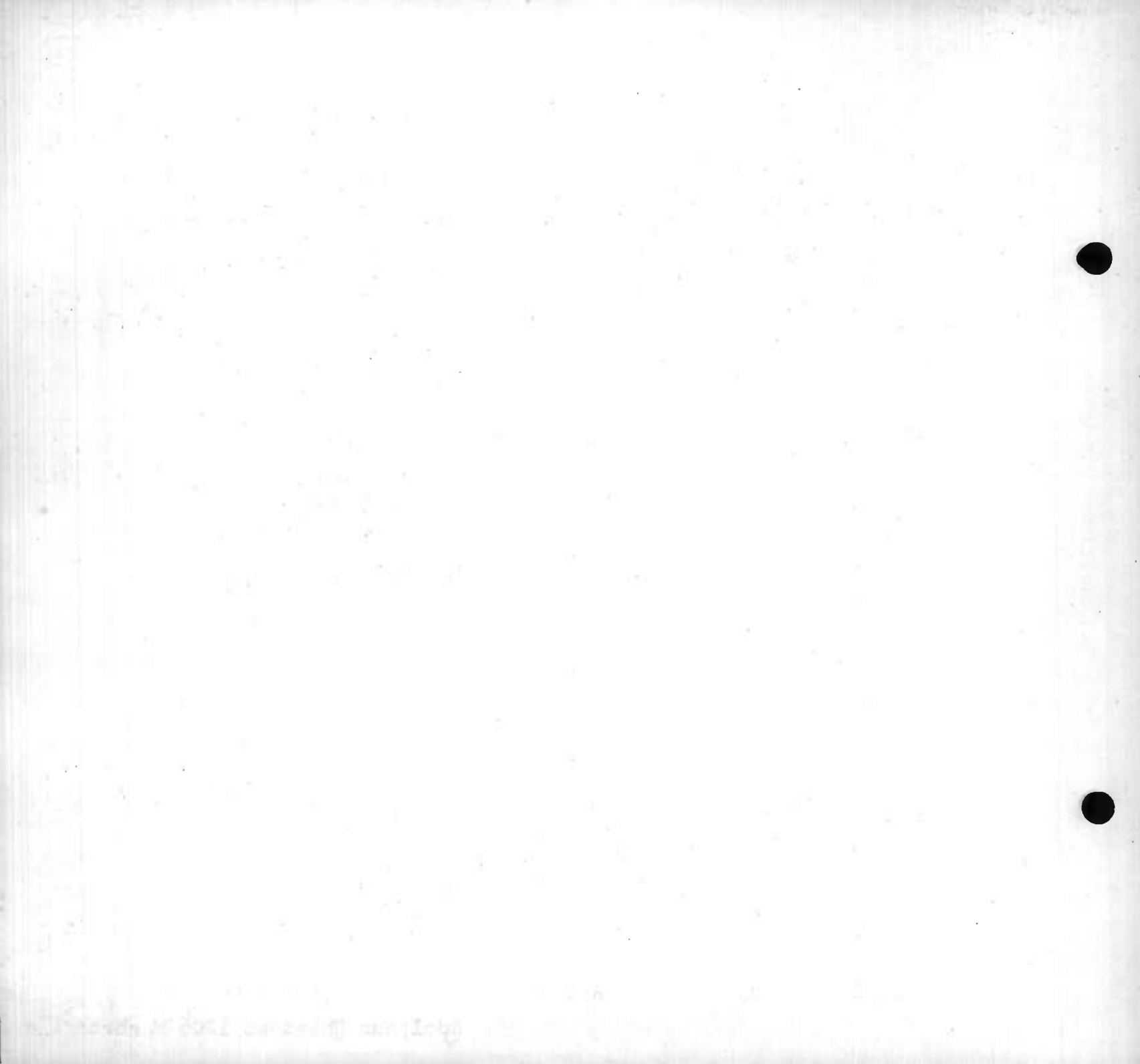
VS 151 REV 1/1/69

WALLLEY HONORARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>257</u> <u>69 6522</u>
BIRTH NO. <u>69 6522</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Thomas, Addie</u>		2. DATE AND HOUR OF DEATH <u>6/24/69</u> <u>4 P.m.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harborview H.C.C.</u>		C. CITY OR TOWN <u>Balti Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
1313 Light Street Baltimore Md 21230		E. STREET AND NUMBER <u>1706 St. Fayette Street</u>		
5. SEX <u>Female</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/91</u>	9. AGE (In years last birthday) <u>78 yrs.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Courtow Md.</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hawkins</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-05-7973</u>		17. INFORMANT <u>Adolphus Halstead</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Heart Block</u> (B) <u>Arteriosclerotic C-V disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Genital arteriosclerosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Rheumatoid Arthritis</u>				<u>10 yrs</u>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from <u>6-5</u> 19 <u>69</u> to <u>6-24</u> 19 <u>69</u> , that (we) last saw the deceased alive on <u>6-24</u> 19 <u>69</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Kenneth Krulovitz MD</u>				23B. DATE SIGNED <u>6/26/69</u>
23C. PHYSICIAN'S NAME (Type) <u>Kenneth Krulovitz MD</u>				23D. ADDRESS <u>115 W. Monument St. Balto Md</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>
24D. LOCATION <u>Baltimore Md</u>		24E. ADDRESS <u>1206 W north Ave</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1969</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>



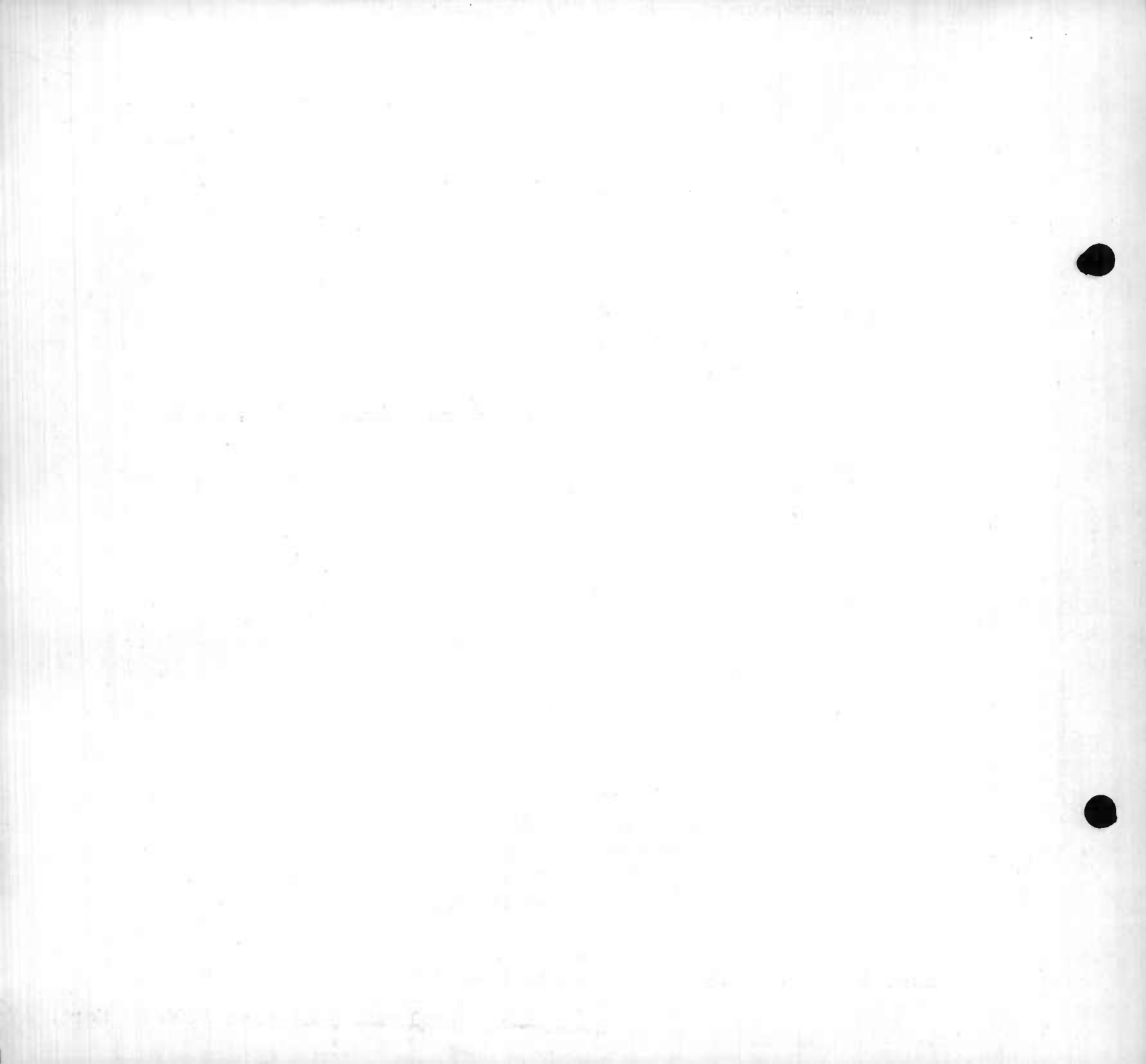
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT 69 6523 CERTIFICATE OF DEATH

REG. NO. 68-7440
69 6523

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SMARTS, FRANK		2. DATE AND HOUR OF DEATH 6-21-69 4 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY 1502		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN Hospital of md			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1607 Mc Kean Ave 21217		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH -91 77	9. AGE (In years lost birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME ?			12. CITIZEN OF WHAT COUNTRY? U S A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Shirley Smith, same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 250.9 I Base - Ventricular insufficiency			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-18 19 69 to 6-21 19 69 , that (I) (we) last saw the deceased alive on 6-21 4 AM 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sy Huh				23B. DATE SIGNED 6-21-69	
23C. PHYSICIAN'S NAME (Type) SOUNG YOUN HUH				23D. ADDRESS LUTHERAN Hospital of md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/69		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetry	
				24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Adolphus H alstead 1206 W North Ave	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6524

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MELVIN WHITE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 20, 1969 2:35 p.m.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1905		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) Columbus S C		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 232-09-4956	
18. INFORMANT Mrs Eliza Liggins		ADDRESS same	

19. CAUSE OF DEATH 481X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cirrhosis of the liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) June 22, 1969 DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/69	
24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetry		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W north AVE	

1905
Columbus St C
U S A
Enoch White
Belle Hammond
Laborer
232-09-4956 Mrs Eliza Higgins, same

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6525
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARRIE M. COLVIN		
2. DATE AND HOUR OF DEATH 6-26-69 9:00 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GENERAL HOSP. 49		
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 27 DUNDALK AVE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-31-97	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria		10B. KIND OF BUSINESS OR INDUSTRY Beit Steel		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME TAYLOR JACKSON		
14. MOTHER'S MAIDEN NAME Vella Shelton		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 712-16-5217		17. INFORMANT GRANIEL COLVIN ADDRESS 323 Roxbury Ct. Joppa, Md. 21085		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) UREMIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA, URINARY (B) DUE TO, OR AS A CONSEQUENCE OF: BLADDER + Metastasis (C) GENERALIZED CARDIOVASCULAR DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/26 1969 to 6/26 1969 , that (I) (we) last saw the deceased alive on 6/26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE MD A Tolentino				23B. DATE SIGNED 6/26/69
23C. PHYSICIAN'S NAME (Type) MARIANO D. TOLENTINO				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL/REMOVAL		24B. DATE 6-30-69		24C. NAME OF CEMETERY OR CREMATORY CRAIGSVILLE CEMETERY
24D. LOCATION (City, town, or county) CRAIGSVILLE, VIRGINIA		(State)		
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Faber, Md.		25C. FUNERAL DIRECTOR GLORICH FUNERAL HOME, DUNDALK, MD.

St. Louis, Mo.

#302

69 6526 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6526
REG. NO.

BIRTH NO.

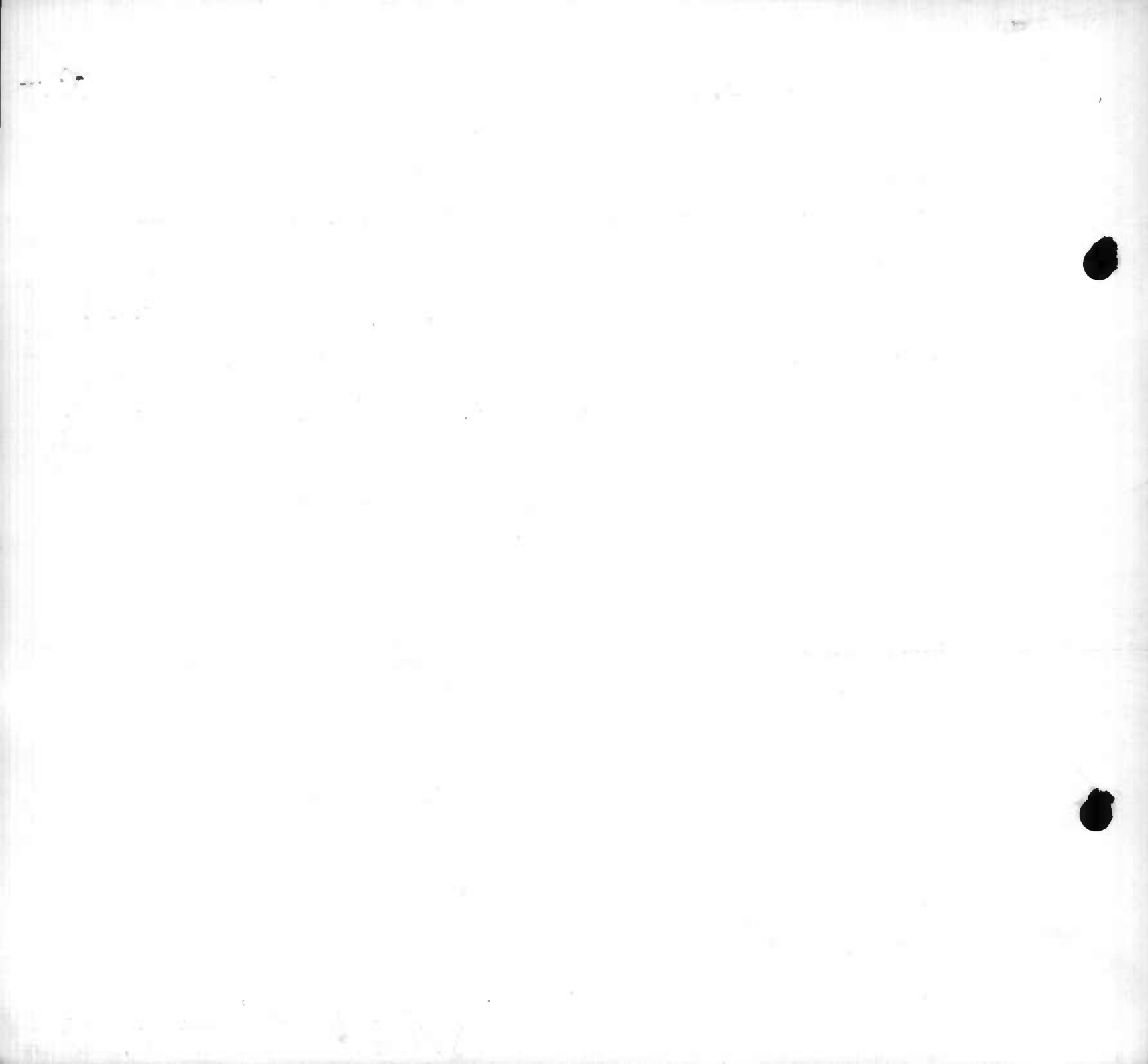
1. NAME OF DECEASED (Type or Print) NORMAN V. HODGES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> June 28, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) (DOA) South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1969 9:25 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2303	
9. DATE OF BIRTH Aug. 7, 1895		10. AGE (In years last birthday) 73 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Rock Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Richard Hodges		14. MOTHER'S MAIDEN NAME Minnie Downey	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		16. KIND OF BUSINESS OR INDUSTRY Paper	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes # 1		18. SOCIAL SECURITY NO.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
27. TIME OF INJURY (Approx.)		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
29. HOW DID INJURY OCCUR?		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
31. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		32. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
33. ACTUAL SIGNATURE Charles S. Springate, M.D.		34. DATE SIGNED June 29, 1969	
35. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		36. DATE OF BURIAL CREMATION, REMOVAL (Specify) Burial	
37. DATE REC'D BY HEALTH DEPT. 7 1 69		38. NAME OF CEMETERY or CREMATORY Glen Haven	
39. NAME OF REGISTRAR Robert E. Taylor, M.D.		40. FUNERAL DIRECTOR Mc Cully 130 E. Fort Ave	
41. ADDRESS 6517		42. DATE JUN 30 1969	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>69-11177</u> <u>69</u> <u>6527</u> CERTIFICATE OF DEATH					REG. NO. <u>69</u> <u>6527</u>				
1. NAME OF DECEASED (Type or Print) <u>NASSAR, Lara Ann</u>					2. DATE AND HOUR OF DEATH <u>6/27/69</u> <u>7:37 A.</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2644</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>The Johns Hopkins Hospital</u>					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <u>5503 B Sarril Road</u> <u>21206</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/69</u>	9. AGE (In years last birthday) <u>5</u>	If Under 1 Yr. Months: <u>5</u> Days: <u>5</u> Hours: <u>5</u> Min. <u>5</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>////////</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor Nassar</u>					14. MOTHER'S MAIDEN NAME <u>Jane Brannon Nassar</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Victor Nassar (father) Same As #4</u>				
18. <u>7469</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6/22</u> <u>1969</u> to <u>6/27</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>6/27</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>R. N. Sheff, M.D.</u>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>6/27/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. N. Sheff, M.D.</u>					23D. ADDRESS <u>The Johns Hopkins Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>June 28/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Sunset Hill Mem. Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Rome, Georgia</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1969</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>R. B. Taylor</u>		ADDRESS <u>Singleton Funeral Home</u> <u>Glen Burnie, Maryland</u>		



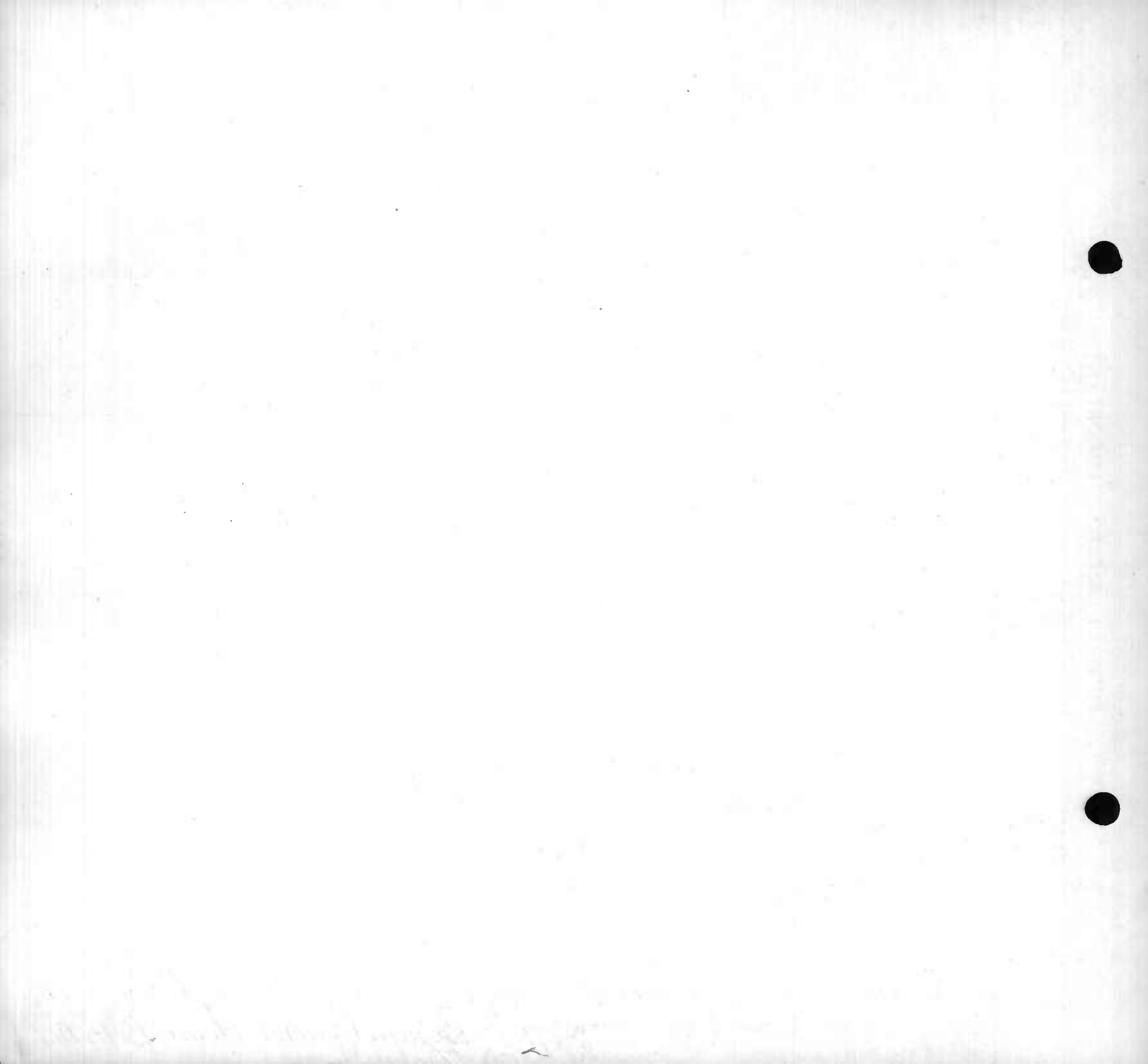
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>69 6528</u>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Staniśława (Stella) Dymowski</u>		2. DATE AND HOUR OF DEATH <u>6-26-69 1 30 P.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>M.D. GEN. HOSP</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1022 S. Linwood</u> <u>AUR</u>		
5. SEX <u>Female</u>	6. RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-93</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. FATHER'S NAME <u>Walter STREKOWSKI</u>		
14. MOTHER'S MAIDEN NAME <u>Adella Grzynkowiak</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-01-1521</u>		17. INFORMANT <u>Mr. Harry J. Dymowski, 1022 S. Linwood Ave. Baltimore, Md. 21224</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMO THORAX</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>POST OPERATIVE Complication</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CHOLECYSTECTOMY</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>6-23-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CHS. JAUNDICE</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>6-23-69</u> 19 <u>69</u> to <u>6-26</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6-26</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Daniel H. White M.D.</u>				23B. DATE SIGNED <u>6-26-69</u>
23C. PHYSICIAN'S NAME (Type) <u>Daniel H. White</u>		23D. ADDRESS <u>M.D. GEN. HOSP.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/1/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda, 2829 Hudson St. Balto. Md.</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) JOHN LAURENCE TAYLOR		2. DATE AND HOUR OF DEATH 6-26-69 1:20 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		13-48	
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		C. CITY OR TOWN Baltimore 21211		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore, Md. 21218		E. STREET AND NUMBER 1319 W. 40th Street			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-01	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10B. KIND OF BUSINESS OR INDUSTRY (S. N. Katz)		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME CURTIS TAYLOR		14. MOTHER'S MAIDEN NAME ETHEL BRUSHMILLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-6023		17. INFORMANT LILA M. TAYLOR (WIFE)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 I		CAUSE OF DEATH		ADDRESS 1319 W. 40th St. Baltimore, Md. 21211	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-20 19 69 to 6-26 19 69 , that (I) (we) last saw the deceased alive on 6-26 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aurora P. Cuevas, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-26-69	
23C. PHYSICIAN'S NAME (Type) AUROPA P. CUEVAS, M.D.		23D. ADDRESS North Charles Gen. Hosp., Baltimore, Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-69		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville Balt Co Md		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Burgess General Home Baltimore		25D. ADDRESS Burgess General Home Baltimore			



K-526

69 6530 BALTIMORE CITY HEALTH DEPARTMENT

69 6530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) CLAUDETTE F. KINCER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 25, 1969 Hour 12:50 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 7-28-69		3. DATE PRONOUNCED DEAD Month Day Year June 25, 1969 Hour 12:50 P.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Dundalk	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 8/31/50		10. AGE (In years last birthday) 18	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward L. Kincer		14. STREET AND NUMBER 8126 N. Boundary Road	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Frances A. Eanes		16. INFORMANT (Father) Mr. Edward L. Kincer, 8126 N. Boundary Rd.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocarditis Interstitial pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. INTERSTITIAL PNEUMONITIS		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 26, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/69	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	

letter from M. E. D. office
7-28-69 M.H.

CERTIFICATE AMENDED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6531	
BIRTH NO.		69 6531		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		HARRY G. JOHNSON		2. DATE AND HOUR OF DEATH JUNE 28, 1969 8 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		A. STATE MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL BALTIMORE, MD. 21201		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY 22-01	
5. SEX M		6. RACE W		C. CITY OR TOWN BALTIMORE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12/8/25		9. AGE (In years last birthday) 43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED		10B. KIND OF BUSINESS OR INDUSTRY Laundry		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 114 WARREN AVE.	
13. FATHER'S NAME HARRY C. JOHNSON		14. MOTHER'S MAIDEN NAME LEONA JOHNSON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII	
16. SOCIAL SECURITY NO.		17. INFORMANT CHART		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH PULMONARY EDEMA + ACUTE RENAL FAILURE GI BLEEDING + MARKED HEPATIC CIRRHOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10/25/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HEPATIC CIRRHOSIS + Esophageal		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/15 1969 to 6/28 1969 that (I) (we) last saw the deceased alive on 6/28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Vicente R. Carag Jr. M.D.		23B. DATE SIGNED 6/28/69	
23C. PHYSICIAN'S NAME (Type) VICENTE R. CARAG JR. M.D.		23D. ADDRESS UNIVERSITY HOSP BALTO, MD. 21201		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-69		24C. NAME OF CEMETERY or CREMATORY City	
24D. LOCATION (City, town, or county) (State) Parsons, W. Va.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Jacob E. Vacker, M.D.	
25C. FUNERAL DIRECTOR Mc Cully		25D. ADDRESS 130 E. Fort Ave		25E. DEGREE	

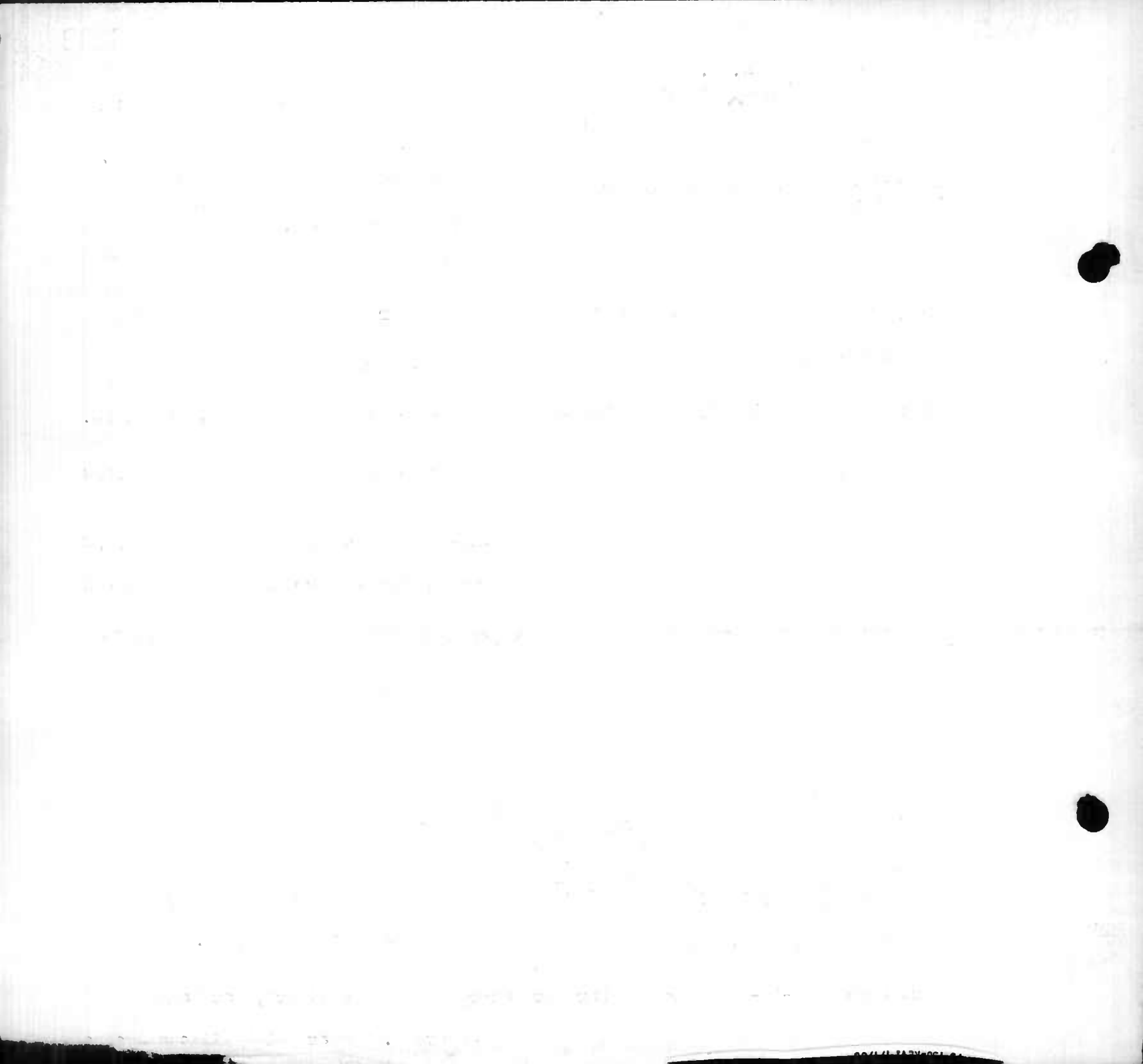


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 6532
BIRTH NO. 69 6532				
1. NAME OF DECEASED (Type or Print) A. H. Neils Poulsen		2. DATE AND HOUR OF DEATH June 25, 1969 3: 35 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Ga. B. COUNTY V-09		
		C. CITY OR TOWN Brunswick		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1232 Wisteria Ave.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/6/97
		9. AGE (in years lost birthday) 72		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Denmark
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lars Poulsen		
14. MOTHER'S MAIDEN NAME Gertrude Schmidt		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> CG 1921-1925		
16. SOCIAL SECURITY NO. 180-12-9953		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral vascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral arteriosclerosis (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Polycythemia vera				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Days Years Years
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR
22. I certify that (I) (this hospital) attended the deceased from June 9 19 69 to June 25 19 69 that (I) (we) last saw the deceased alive on June 25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE John C. Sutherland, M.D.				23B. DATE SIGNED 6/26/69
23C. PHYSICIAN'S NAME (Type) John C. Sutherland, MD		23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-28-69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		
25B. NAME OF REGISTRAR Howard H. Hubbard, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Avenue		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6533 CERTIFICATE OF DEATH

REG. NO. 69 6533

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BARKER, MARY LUCETTA		2. DATE AND HOUR OF DEATH 6 27 69 11:55A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-72			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2406 1/2 BROHAWN AVE 21230			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 24 03	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME GEORGE BURKHART		14. MOTHER'S MAIDEN NAME LOTTIE SCHEIB	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217126456		17. INFORMANT James F. Barker 2406 1/2 Brohawn Ave. 21230	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1890 I CAUSE OF DEATH metastatic Renal cell carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6/31 1969 to 6/27/ 1969 that (X) (we) last saw the deceased alive on 6/27/69 19 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruben V. Lima MD		23B. DATE SIGNED 6-27-69		23C. PHYSICIAN'S NAME (Type) RUBEN V. LIMA MD	
23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6-30-69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229	

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ATTEN: J. M. J. J. J. J.

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6534				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. 69 6534			
1. NAME OF DECEASED (Type or Print) LOUISA M. LAWRENCE								2. DATE AND HOUR OF DEATH 6/25/69 14¹⁰ P M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY OF MARYLAND HOSPITAL								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 26-11							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL								C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>								8. DATE OF BIRTH 12/1/95				9. AGE (In years last birthday) 73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE								10B. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (State or foreign country) MD.			
13. FATHER'S NAME PETER SOHN								14. MOTHER'S MAIDEN NAME BARBARA HERALD							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No								16. SOCIAL SECURITY NO. 212-22-7988				17. INFORMANT Pt's DAUGHTER			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PRIMARY HEMORRHAGIC THROMBOCYTOSIS								(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS.			
19A. DATE OF OPERATION 3/6/20/69								19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 1/1/69 CHEST BIOPSY				20A. AUTOPSY? (Yes or No) YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No								21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —								21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 6/17 19 69 to 6/25 19 69 that (I) (we) lost saw the deceased alive on 6/25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												23A. SIGNATURE Bruce Fleegler		23B. DATE SIGNED 6/25/69	
23C. PHYSICIAN'S NAME (Type) M.D.								23D. ADDRESS —							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 6/30/69				24C. NAME of CEMETERY or CREMATORY DAK LAWN				24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. —				25B. NAME OF REGISTRAR JOB. CONNELL				25C. FUNERAL DIRECTOR 5003				ADDRESS 300 N. ACE			



FUNERAL DIRECTOR: IMPORTANT

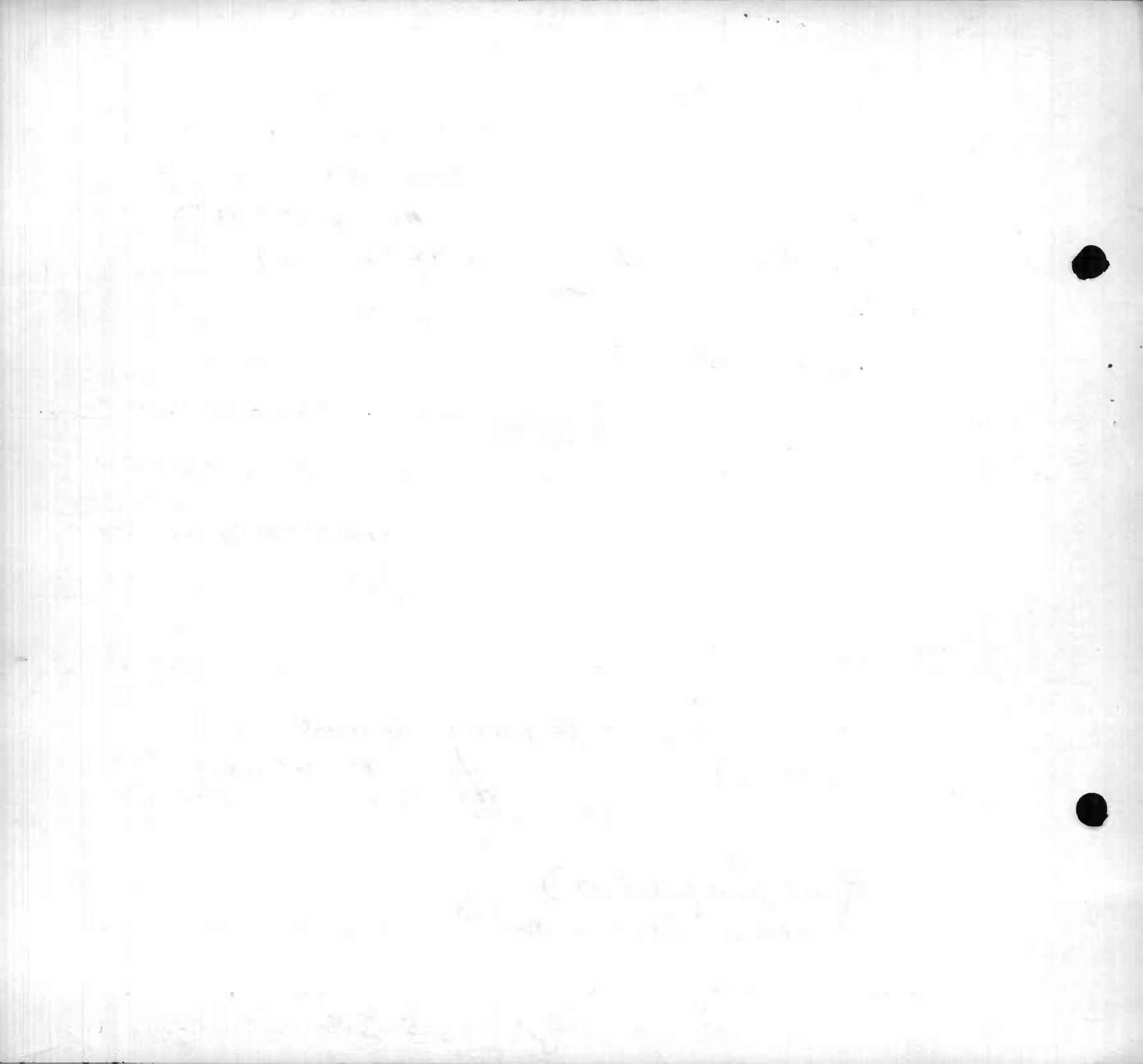
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 6535		CERTIFICATE OF DEATH		69 6535			
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
				JOSEPH E. JOHNSON		6/26/69		6:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY					
Maryland Gen. Hospital				Md.				1-01			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
				E. STREET AND NUMBER							
				703 S. Linwood Ave.							
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/9/1900	68	FIRE DEPT.		Baltimore		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
WALTER JOHNSON											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, never unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				24-24-9476		Florence L. Johnson		84A			
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				ACUTE MYOCARDIAL INFARCTION 3 DAYS							
I (this does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				ASCVD							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
				(C) DUE TO, OR AS A CONSEQUENCE OF:							
II				ACUTE PULMONARY EDEMA							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 6/23 1969 to 6/26 1969 that (I) (we) last saw the deceased alive on 6/26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
E. M. De Los Santos M.D.				6/26/69							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
E. M. De Los Santos M.D.				N.G.A.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
BURIAL		6/30/69		GARDENS OF FAITH		BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
JUN 30 1969		J. E. Taylor, M.D.		J. J. Connelley		Essex Md.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

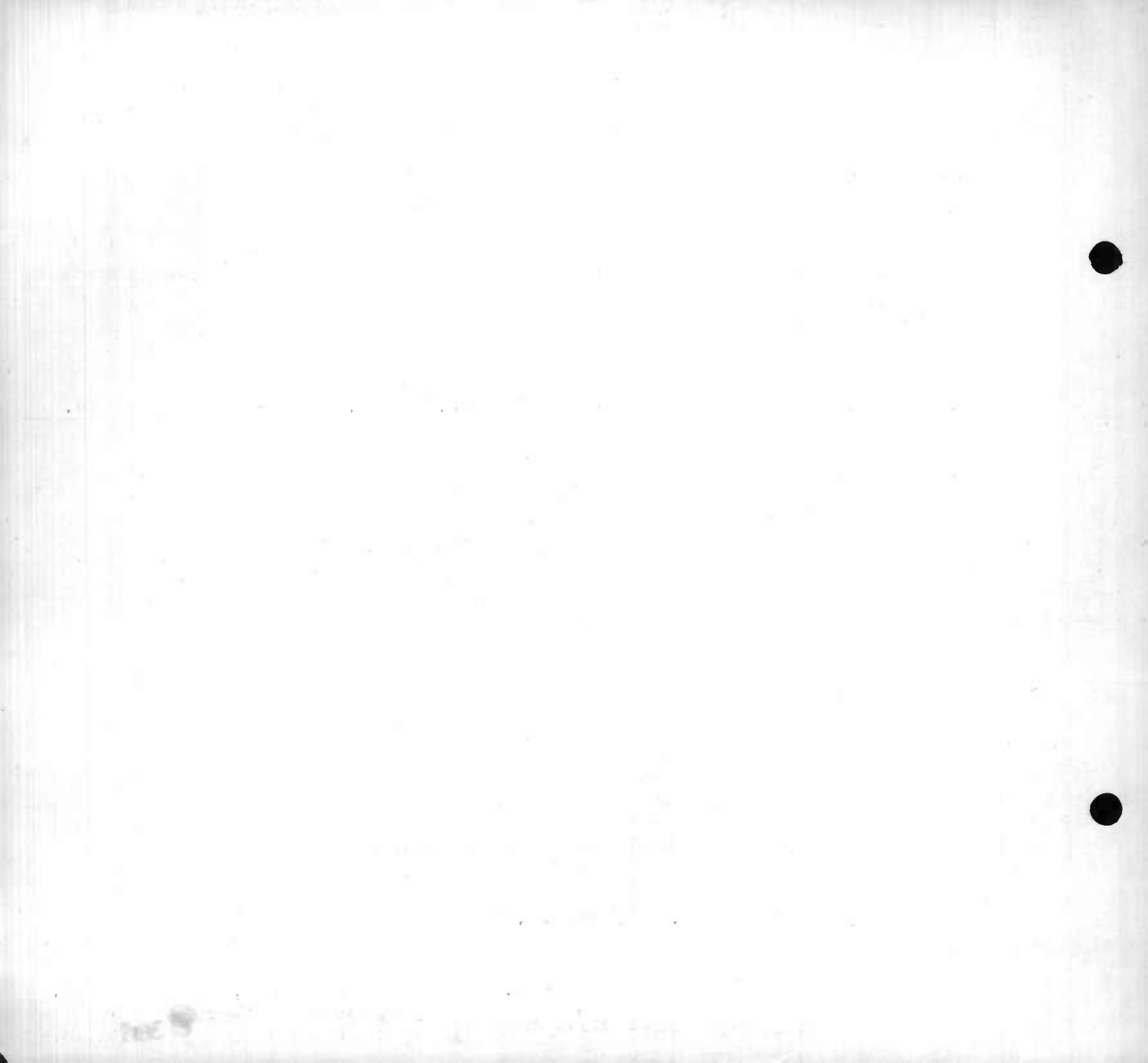
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6536
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 69 6536 CERTIFICATE OF DEATH </div>				
1. NAME OF DECEASED (Type or Print) WANDA D MORRISON		2. DATE AND HOUR OF DEATH 6/25/69 12:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY HARFORD C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4740 LIBERTY HIGHS 28-41		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/22	9. AGE (In years lost birthday) 47
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME E. George Dasch		
14. MOTHER'S MAIDEN NAME Garrett		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT William D. Morrison-4740 Liberty Hgts. Av		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 430.91 RESPIRATORY FAILURE POST-CEREBRAL ANEURYSM SUBARACHNOID HEMORRAGE from rupture of aneurysm of circle of Willis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) II		19A. DATE OF OPERATION		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) @ home		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) @ home		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 6/16/69		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? At Fall with head		
22. I certify that (I) (this hospital) attended the deceased from 6/16/69 19 to 6/25/69 19 that (I) (we) last saw the deceased alive on 6/25-2 PM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Karl Rosewfeld		23B. DATE SIGNED 6/15/69		23C. PHYSICIAN'S NAME (Type) KARL ROSEWELDON
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-69		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Agma-cost		
ADDRESS 4600 Liberty Hts				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

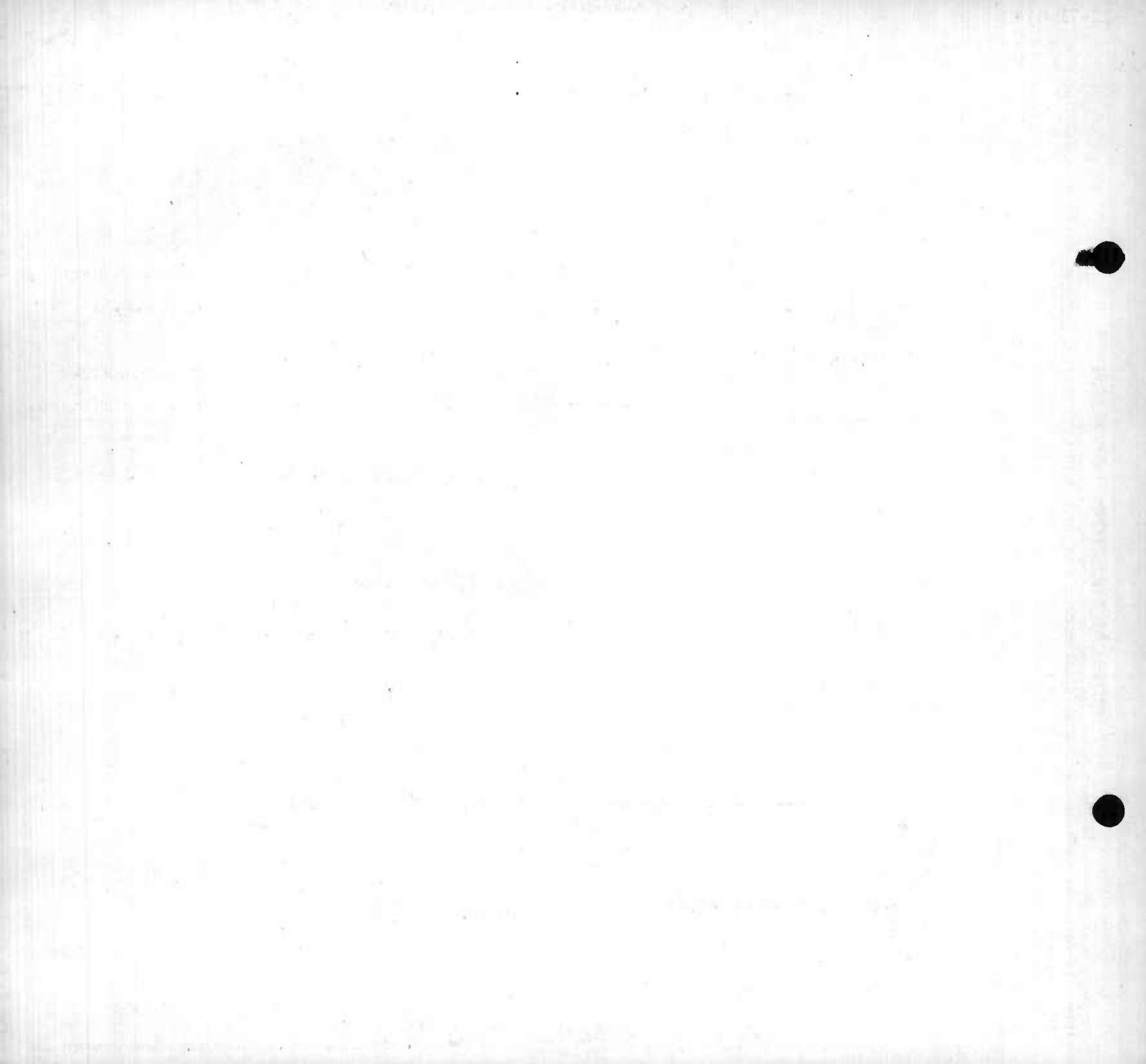
69 6537		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6537	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Louise Caldwell		June 26, 1969 12:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			MARYLAND		
NORTH CHARLES GEN. HOSP.			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			717 W. 37 th ST.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	W		12/17, 1896	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ERNEST O'NESTA		MARGARET Rombillion		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-20-8219		Mrs. Edna M. Weihe -6034 Nahant Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
576.9 I		Massive pulmonary embolism			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Mural Thrombosis, Pericardial appendage Heart			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		myocardial hypertrophy			
		(C) Ruptured gall bladder = focal P/O peritonitis.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 13 1969 to June 26 1969, that (I) (we) last saw the deceased alive on June 26 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Adoracion B. Paulino M.D.				June 26, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Brecker				North Charles Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/30/69		Moreland Mem. Park	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 30 1969		E. Taylor M.D.		Donovan Funeral Home 3018 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

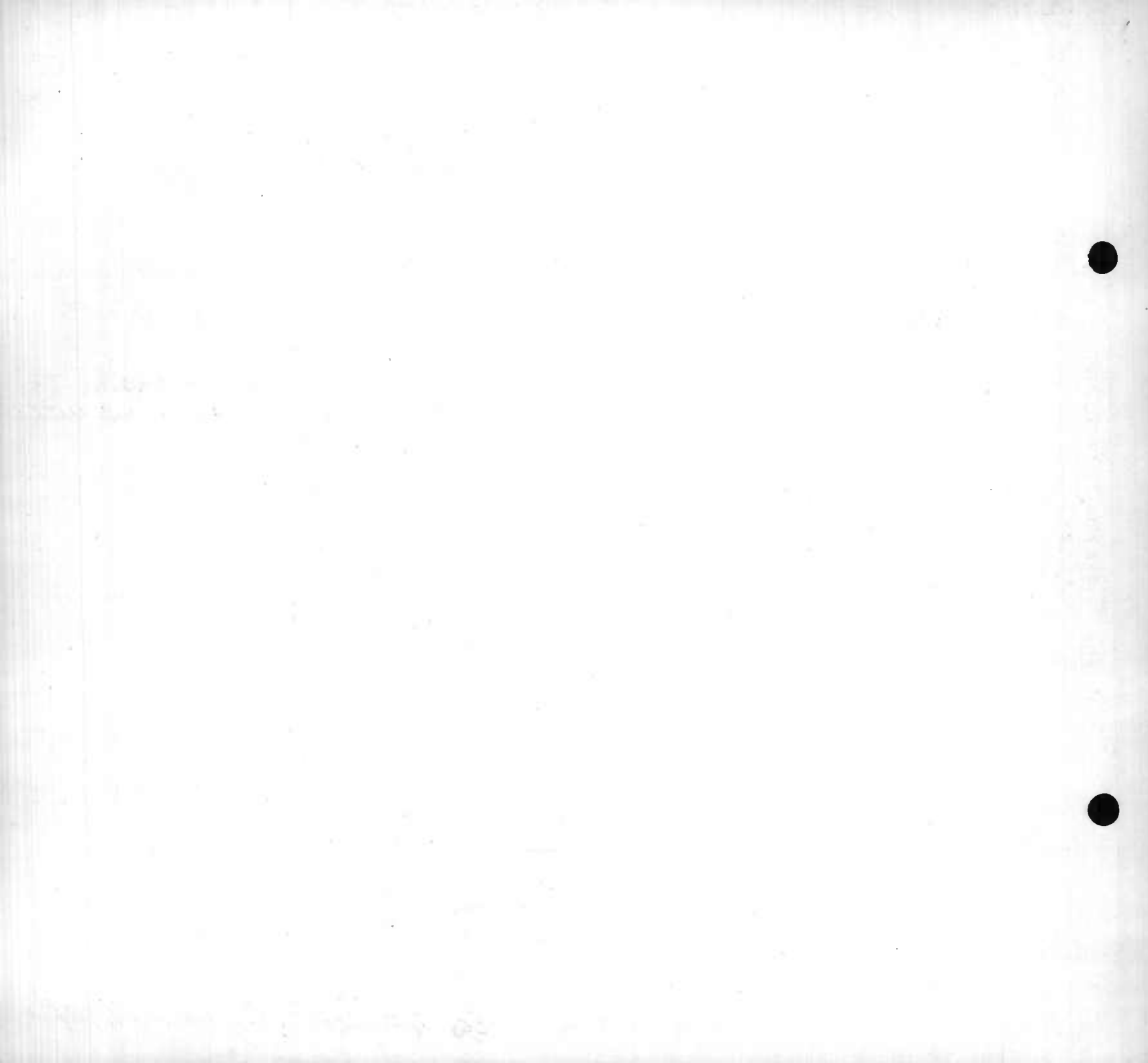
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 812289 6538			
1. NAME OF DECEASED (Type or Print) HARTZELL William E.				2. DATE AND HOUR OF DEATH 12:30 AM 6/26/69							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
E. STREET AND NUMBER Wilson Point Rd. BOX 60 BEACH DRIVE 21221											
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-1918	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired chauffeur				10B. KIND OF BUSINESS OR INDUSTRY Glenn L. Martin				11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John M. Hartzell				14. MOTHER'S MAIDEN NAME Mary E. Knorr			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI				16. SOCIAL SECURITY NO. 213-03-8256A				17. INFORMANT BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.			
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiovascular Arrest				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable MI & Pulmonary Congestion				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO, OR AS A CONSEQUENCE OF: Concussion & fracture of skull				(C) 24 hours?			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED X		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) X		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) X		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? X	
22. I certify that (I) (this hospital) attended the deceased from 6/26 19 69 to 6/26 19 69 , and that (we) last saw the deceased alive on 6/26 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE John Cohen M.D.								23B. DATE SIGNED 6/26/69			
23C. PHYSICIAN'S NAME (Type) JOHN COHEN M.D.								23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR John A. Cohen, Inc.		25C. FUNERAL DIRECTOR John A. Cohen, Inc.		25D. ADDRESS 3000 E. Baltimore St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Florence M. Foote</i>				2. DATE AND HOUR OF DEATH <i>6/28/69</i> <i>7:45 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harker View NCC</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
E. STREET AND NUMBER <i>#1220</i>							
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/5/89</i>	9. AGE (In years lost birthday) <i>80</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>JOHN LEE</i>		14. MOTHER'S MAIDEN NAME <i>EMMA (?)</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>218-01-9363D</i>		16. SOCIAL SECURITY NO. <i>218-01-9363D</i>	
17. INFORMANT <i>JOHN C. FOOTE</i>		18. <i>440.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Coronary atherosclerosis</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-5</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>6-6-1969</i> to <i>6-28-1969</i> , that (2) (we) last saw the deceased alive on <i>6-28-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. C. HLEVIL</i>				23B. DATE SIGNED <i>6/28/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>A. C. HLEVIL 24705, MD</i>				23D. ADDRESS <i>1203 4th Paul St Baltimore MD 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/30/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>MEADOWRIDGE</i>		24D. LOCATION (City, town, or county) (State) <i>DORSEY, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1969</i>		25B. NAME OF REGISTRAR <i>John E. Gabe, MD.</i>		25C. FUNERAL DIRECTOR <i>W. B. Burtley, New York, NY</i>		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6540				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 6540	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) LUKAS JOHN (Lukas)		2. DATE AND HOUR OF DEATH 6/28/69 4:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital 36		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 19-02	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1409 Hollins St.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 11/15/88		9. AGE (In years lost birthday) 80 ?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Relieved		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LITHUANIA EUROPE		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Vera Gedra		ADDRESS 1409 Hollins St	
18. 34579 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO - Uraemic Coma = CVA & I Bleeding (B) DUE TO - Epilepsy (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/21/69 to 6/28/69 that (I) (we) last saw the deceased alive on 6/28/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Surinder				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/28/69	
23C. PHYSICIAN'S NAME (Type) SURINDER				23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-2-69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Phyllis E. Kelly, R.D.		25C. FUNERAL DIRECTOR James B. Oshrook 210 Frederick Ave		ADDRESS	

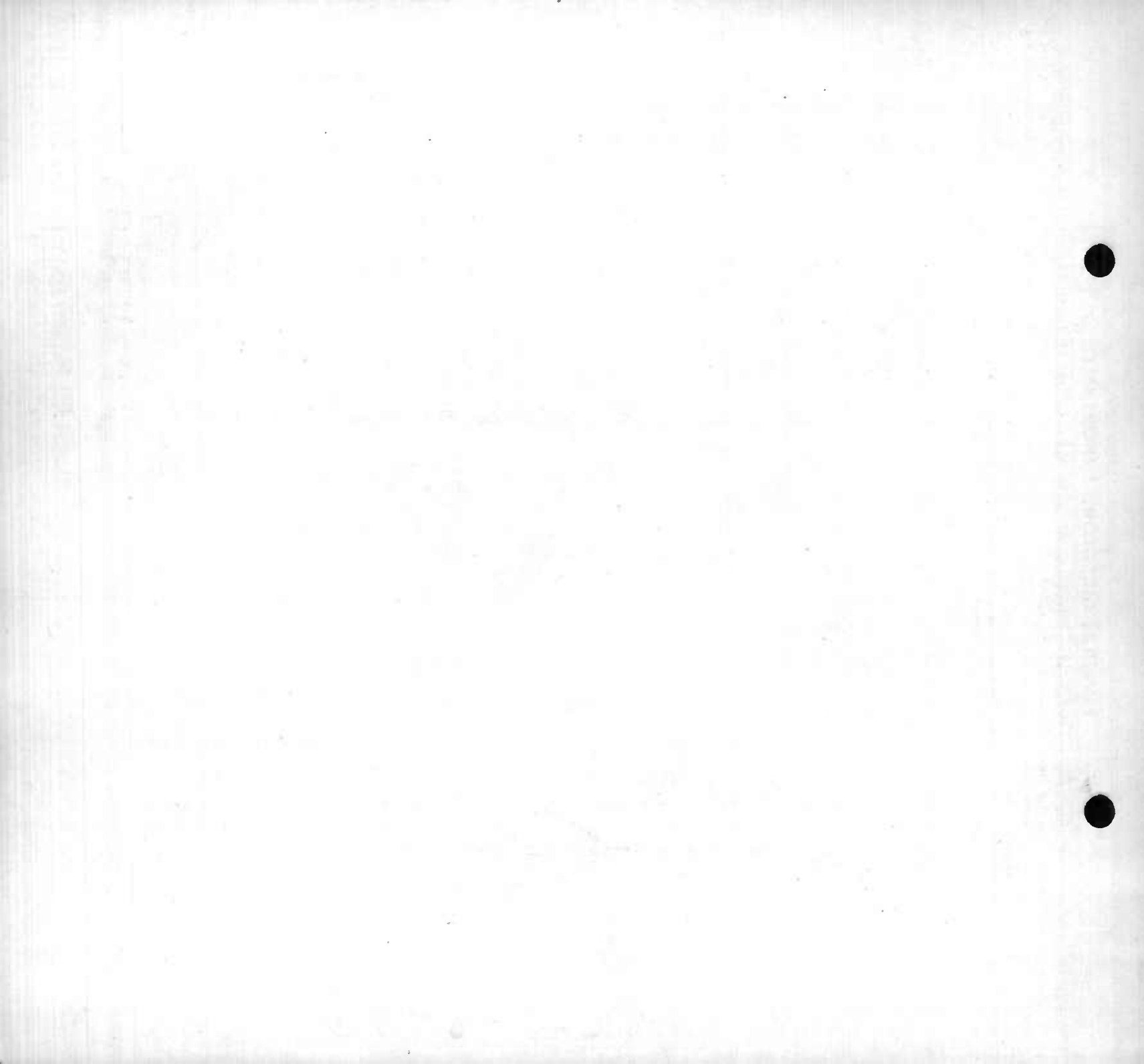
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6541 CERTIFICATE OF DEATH

REG. NO. 69 6541

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Howard Reck		2. DATE AND HOUR OF DEATH 6/28/69 5:45 PM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 4-01			
FULL NAME OF HOSPITAL OR INSTITUTION Melchor Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2327 N. Charles St		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/1899	
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Reck				14. MOTHER'S MAIDEN NAME MARY Stake			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-03-1274		17. INFORMANT Edna Thomas		ADDRESS 309 Bentall St	
18. 345.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Epileptic seizure - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Epileptic seizure (B) Generalized arteriosclerosis (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from February 1967 to June 28 1969 , that (we) last saw the deceased alive on June 18 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Allan L. J. [Signature]				23B. DATE SIGNED 6/28/69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS	
Dr. L. M. [Signature]		Dr. L. M. [Signature]		George S. Schwab, Jr.		Dr. L. M. [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/69		24C. NAME OF CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR		ADDRESS	
				George S. Schwab, Jr.		Dr. L. M. [Signature]	



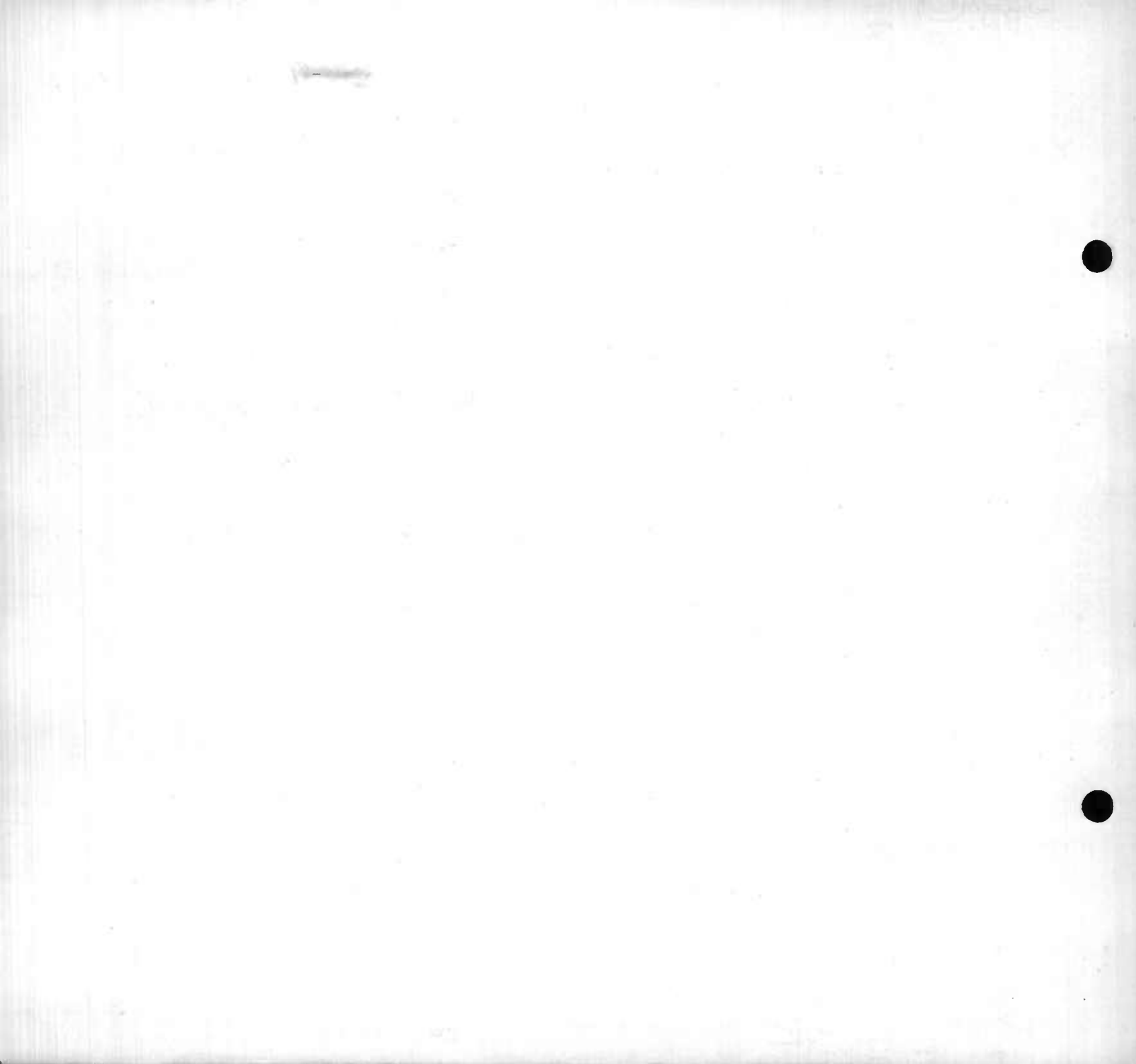
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 6542**

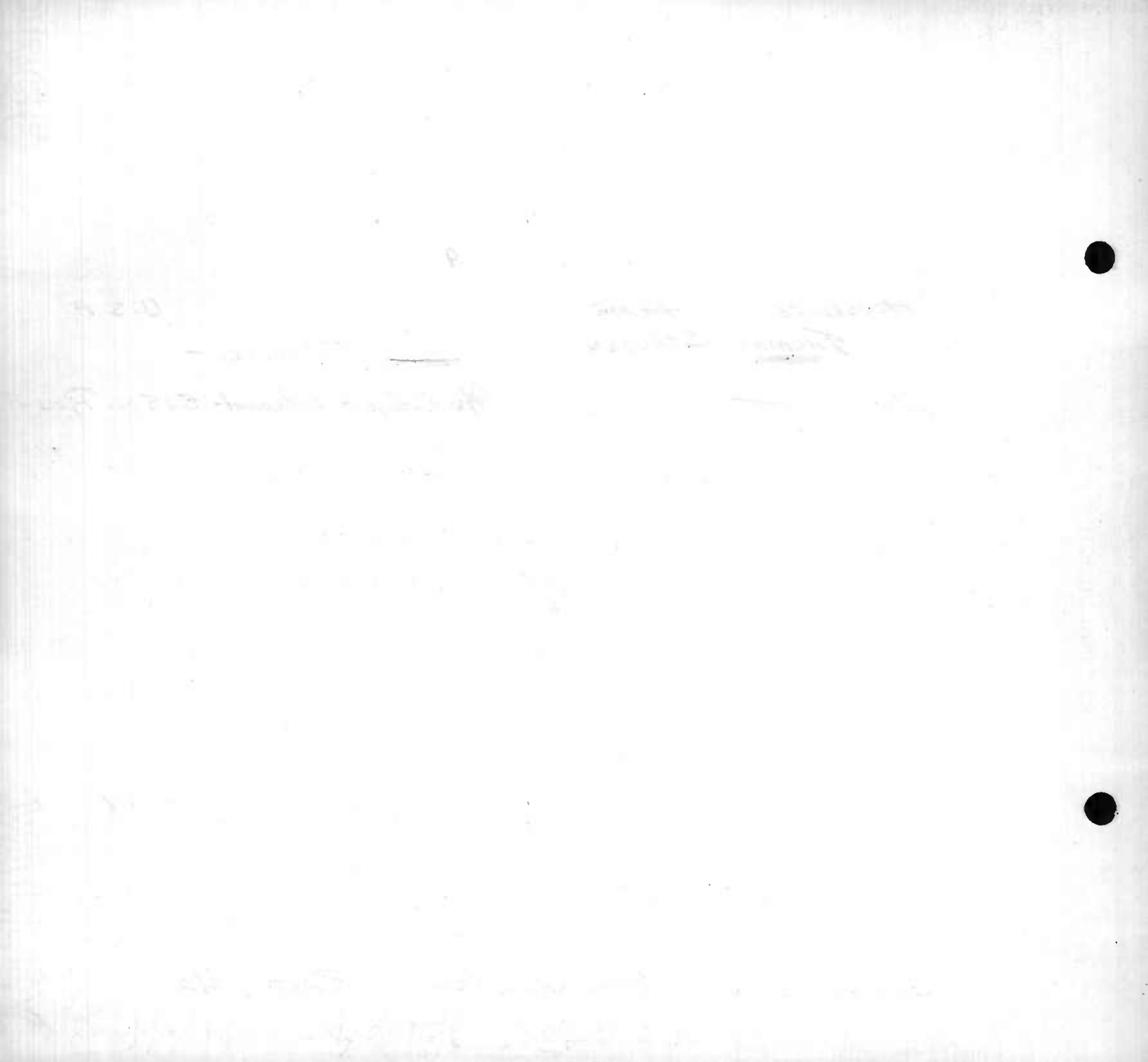
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY KRICHBAUM LINDSEY		2. DATE AND HOUR OF DEATH 6-29-69 7: A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION BOLTON H ILL NURSING CENTER			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 5508 South Bond RD					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-78	9. AGE (In years lost or gained) 90	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BRISTOL, PENNSYLVANIA	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Jacobus (542-3804)	
18. 4379 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) arteriosclerotic heart disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriosclerotic, generalized DUE TO, OR AS A CONSEQUENCE OF: years			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/2 1969 to 6/29 1969 , that (I) (we) lost saw the deceased alive on 6/29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. MACHT				23B. DATE SIGNED 6/29/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.				23D. ADDRESS 2 E READ ST Baltimore 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/69		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Jacobus M.D.		25C. FUNERAL DIRECTOR Corbett Funeral Home	
				ADDRESS 399 Hoover Ave Bloomfield N.J.	



FUNERAL DIRECTOR: IMPORTANT

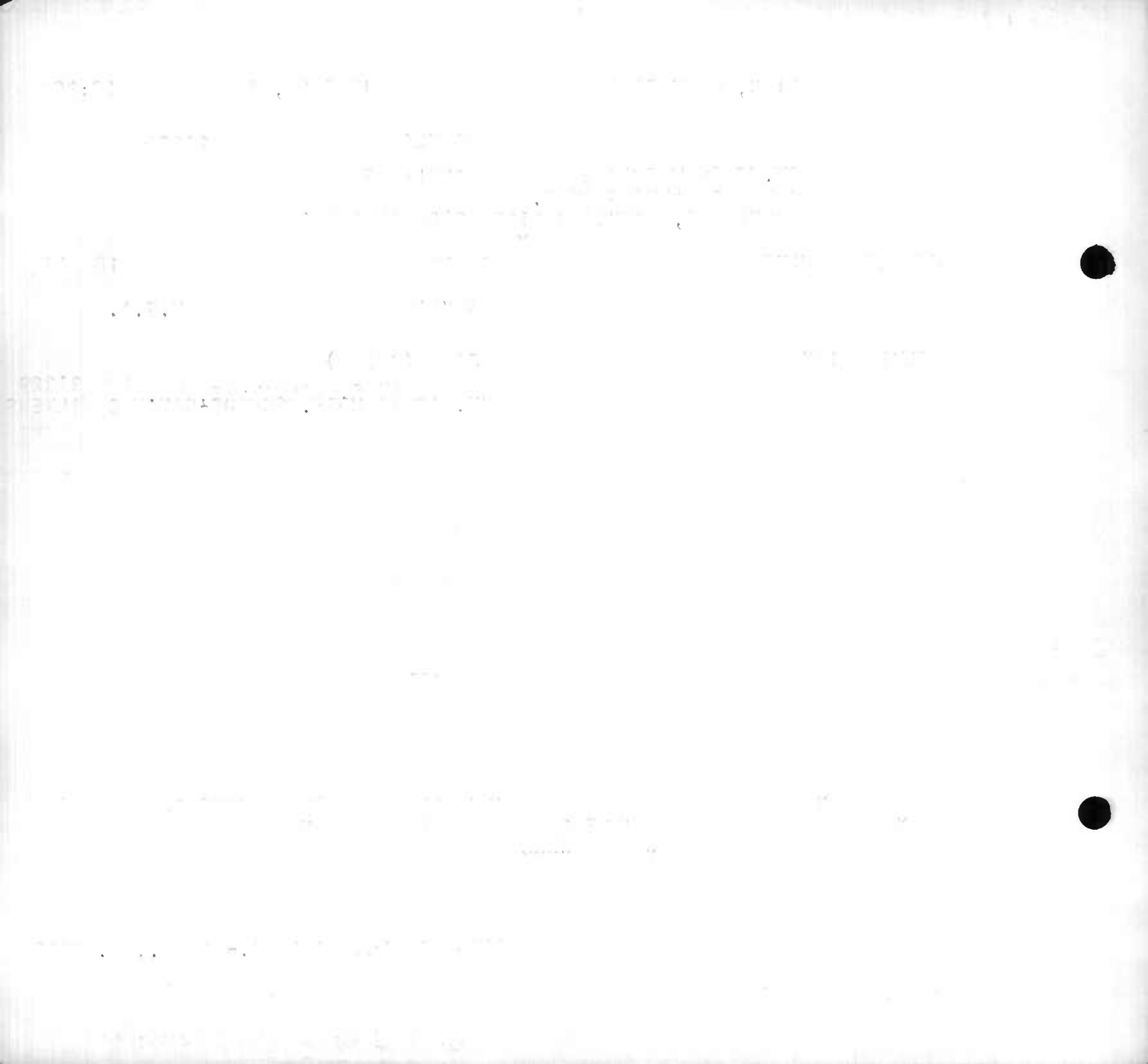
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6543
BIRTH NO. 69 6543		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BETZ, Marie ROSALIE			2. DATE AND HOUR OF DEATH June 26, 1969 10:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bolton Hill Nursing & Convalescent Ctr.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 26-08		
FULL NAME OF HOSPITAL OR INSTITUTION 90			C. CITY OR TOWN Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3818 Mt. Pleasant Avenue					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-96	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME THOMAS STRUBEN			14. MOTHER'S MAIDEN NAME ROSALIE -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-1522		17. INFORMANT Mrs. Evelyn B. Holland - 505 N. Rose St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 433.9 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cerebral thrombosis (B) Coronary artery disease (C) generalized arteriosclerosis		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/24/69 year year		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 10/31/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED choleystitis		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1/69 to 6/26/69 , that (I) (we) last saw the deceased alive on 6/26/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. MAENT MD				23B. DATE SIGNED 6/27/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MAENT MD				23D. ADDRESS 21 E. Reed St Baltimore MD 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-30-69		24C. NAME OF CEMETERY or CREMATORY OAK LAWN Cem.	
24D. LOCATION (City, town, or county) (State) BALTO., MD					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Walter E. Talley, Jr.		25C. FUNERAL DIRECTOR Jefferson Stc	
25D. ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69-11981		69 6544		BALTIMORE CITY HEALTH DEPARTMENT		X		69 6544	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				74	
LINK, BABY GIRL				JUNE 28, 1969				10:30A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institutions residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229				A. STATE MARYLAND				B. COUNTY BALTO. CO. 21227 53-00	
				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2429 ALMA ROAD					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06 27 69	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Mins.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME MELVIN LINK			14. MOTHER'S MAIDEN NAME CAROL (QUINN)			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT AVES BALTIMORE MD ADDRESS 21229 ST. AGNES HOSP. RECORDS - CATON & WILKENS			
18. 77501 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hemolytic Anemia (B) DUE TO, OR AS A CONSEQUENCE OF: Rb. Incompatibility (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from JUNE 27 1969 to JUNE 28 1969 that (X) (we) last saw the deceased alive on JUNE 28 1969 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) view the body after death.									
23A. SIGNATURE P. Aziz, M.D.				23B. DATE SIGNED 6-29-69					
23C. PHYSICIAN'S NAME (Type) P. Aziz, M.D.				23D. ADDRESS CATON & WILKENS AVES. - BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-69		24C. NAME OF CEMETERY OR CREMATORY Landon Park		24D. LOCATION (City, town, or county) (State) Balto. Md			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Geoffrey 2101 Frederick Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

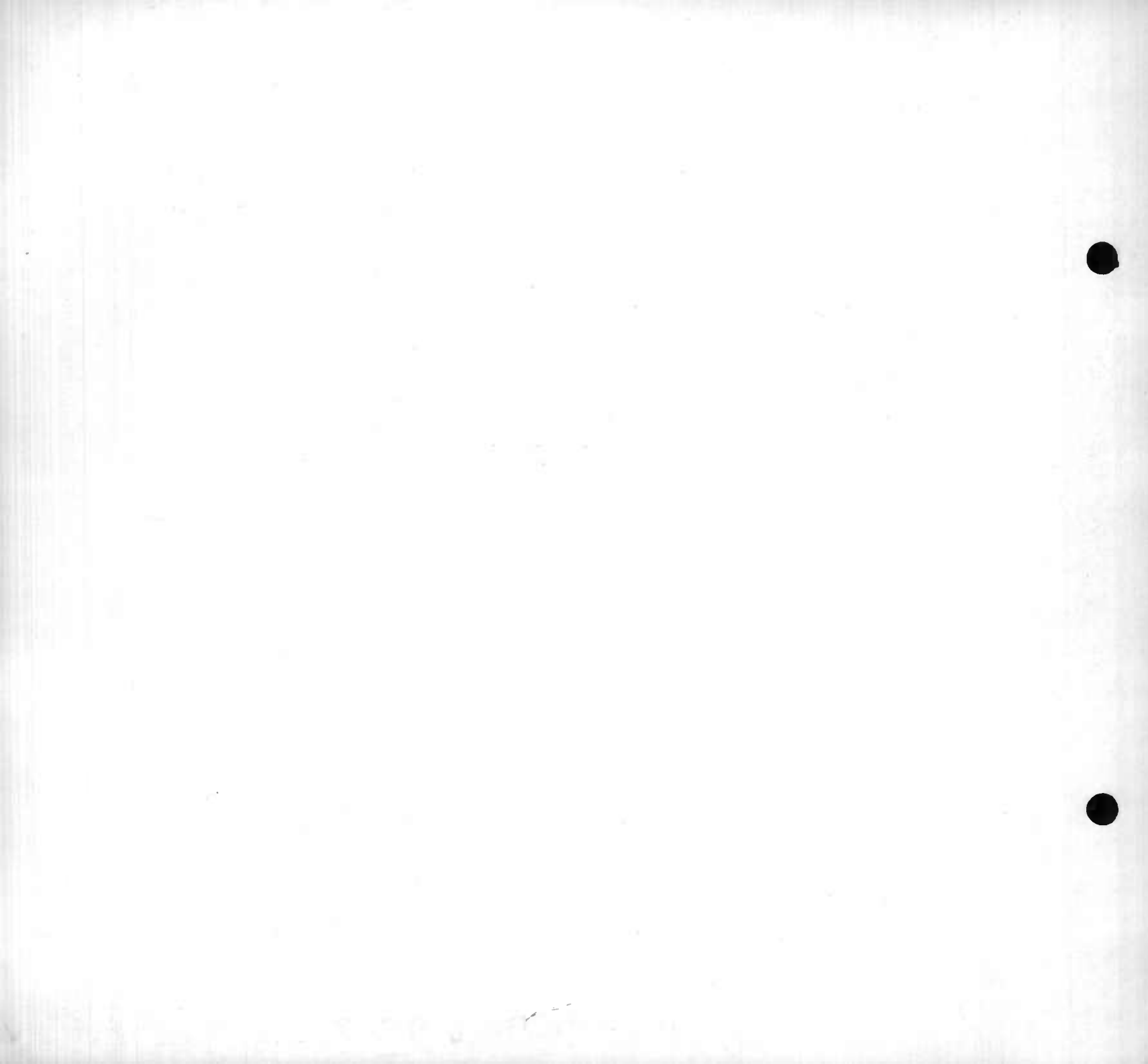
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>69 6545</u>	
BIRTH NO. <u>69-12227</u>		69 6545			
1. NAME OF DECEASED (Type or Print) <u>Thomas C. Paesch</u> <u>Baby Boy Paesch</u>		2. DATE AND HOUR OF DEATH <u>6/27/68</u> <u>10³⁶</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>23-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital Inc.</u> <u>301 St. Paul place. 21202</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1207 S. Hanover St.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/27/68</u>	9. AGE (in years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA, Pa. Ho.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Fred Paesch</u>			14. MOTHER'S MAIDEN NAME <u>Joan Miles</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Rec'ds Mercy Hosp</u>	
18. <u>77891</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cardiorespiratory failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hours</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 27</u> 19 <u>68</u> to <u>June 27</u> 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>June 27</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. K. Shin, M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>S. K. SHIN, M.D.</u>				23D. ADDRESS <u>Mercy Hospital, Inc.</u>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>6-30-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	
24D. LOCATION <u>Stonely Burnie Md.</u>		24E. CITY, TOWN, OR COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>McCully</u>	
25D. ADDRESS <u>130 E. Fort Ave, 21230</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6546	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>EDWARD F MYERS</i>		2. DATE AND HOUR OF DEATH <i>6-26-69 6:45 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>23-03</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>1820 Light St.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1820 Light St</i>	
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-4-05</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DR. H. B. O. R. K.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
13. FATHER'S NAME <i>FRANK R.</i>			14. MOTHER'S MAIDEN NAME <i>MARY TEPPER</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>FAMILY - JANE</i>	
18. <i>156.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Carcinoma bilian ducts, metastasis to the liver</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19 <i>69</i> to <i>June 26</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>June 25</i> , 19 <i>69</i> and that in (my), (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. Lozada</i>				23B. DATE SIGNED <i>6/27/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>RICHARDO LOZADA</i>				23D. ADDRESS <i>1228 S. Charles St. Bldg. 2123</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>6-30-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Edgar Lee</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>		25C. FUNERAL DIRECTOR <i>1306 Fort Ave</i>	

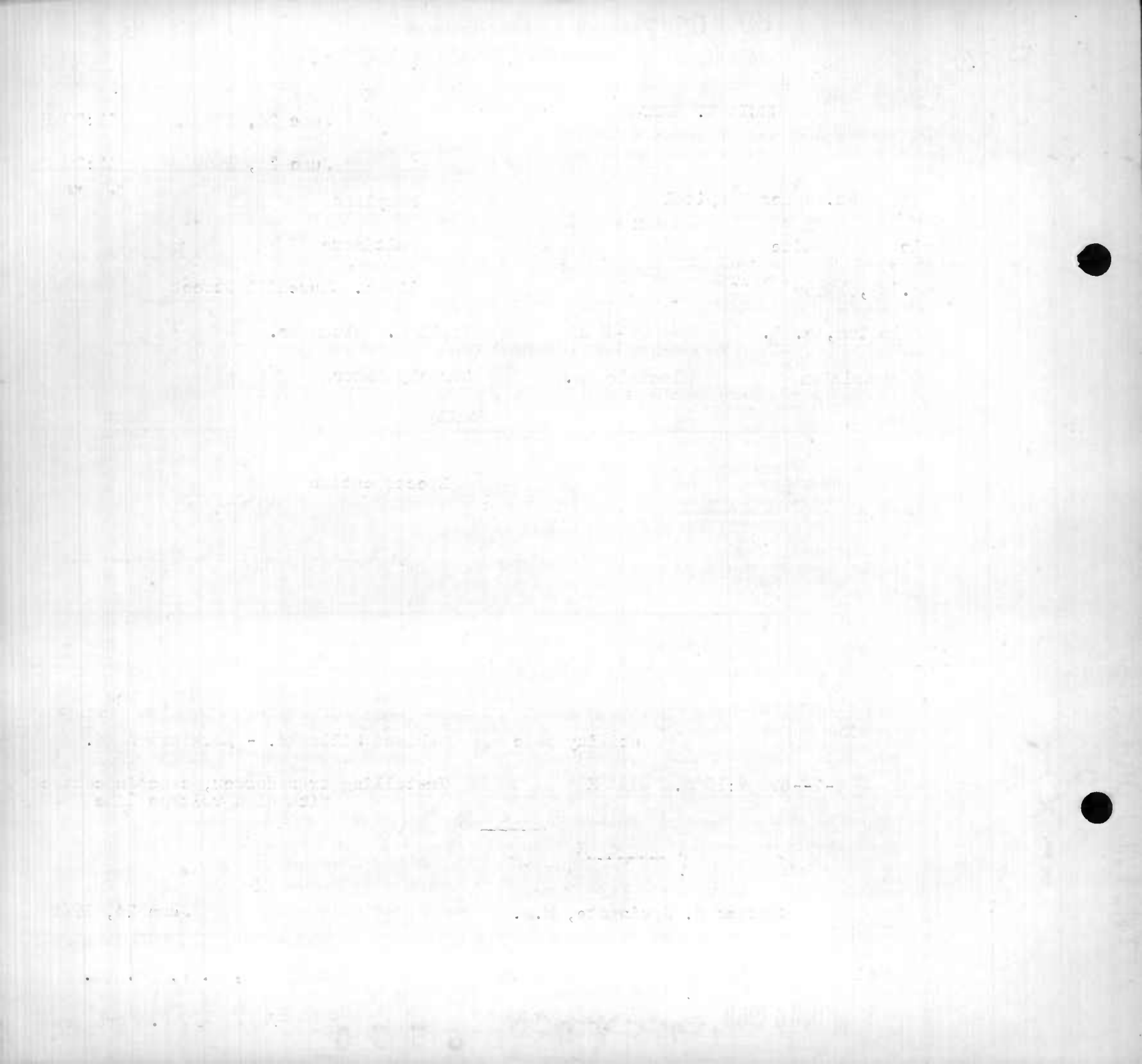


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) CECIL R. HUTTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 26, 1969 12:20 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 26, 1969 12:20 PM	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 22-01	
9. DATE OF BIRTH Aug. 23, 1946		10. AGE (In years last birthday) 22	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		14B. KIND OF BUSINESS OR INDUSTRY Electric Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. _____	
15. MOTHER'S MAIDEN NAME Dorothy Baker		18. INFORMANT Family	
19. E 925.18 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Electrocution (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) utility pole	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Oakland Mills Rd. - Lark Brown Rd.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 6-26-69 9:10 A. m.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 4		22F. HOW DID INJURY OCCUR? Installing transformer, came in contact with high voltage line	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		21. AUTOPSY? (Yes or No) Yes CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 26, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 28 69	
24C. NAME of CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR August E. Faber, M.D.	
25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 1130 E. Fort Ave	

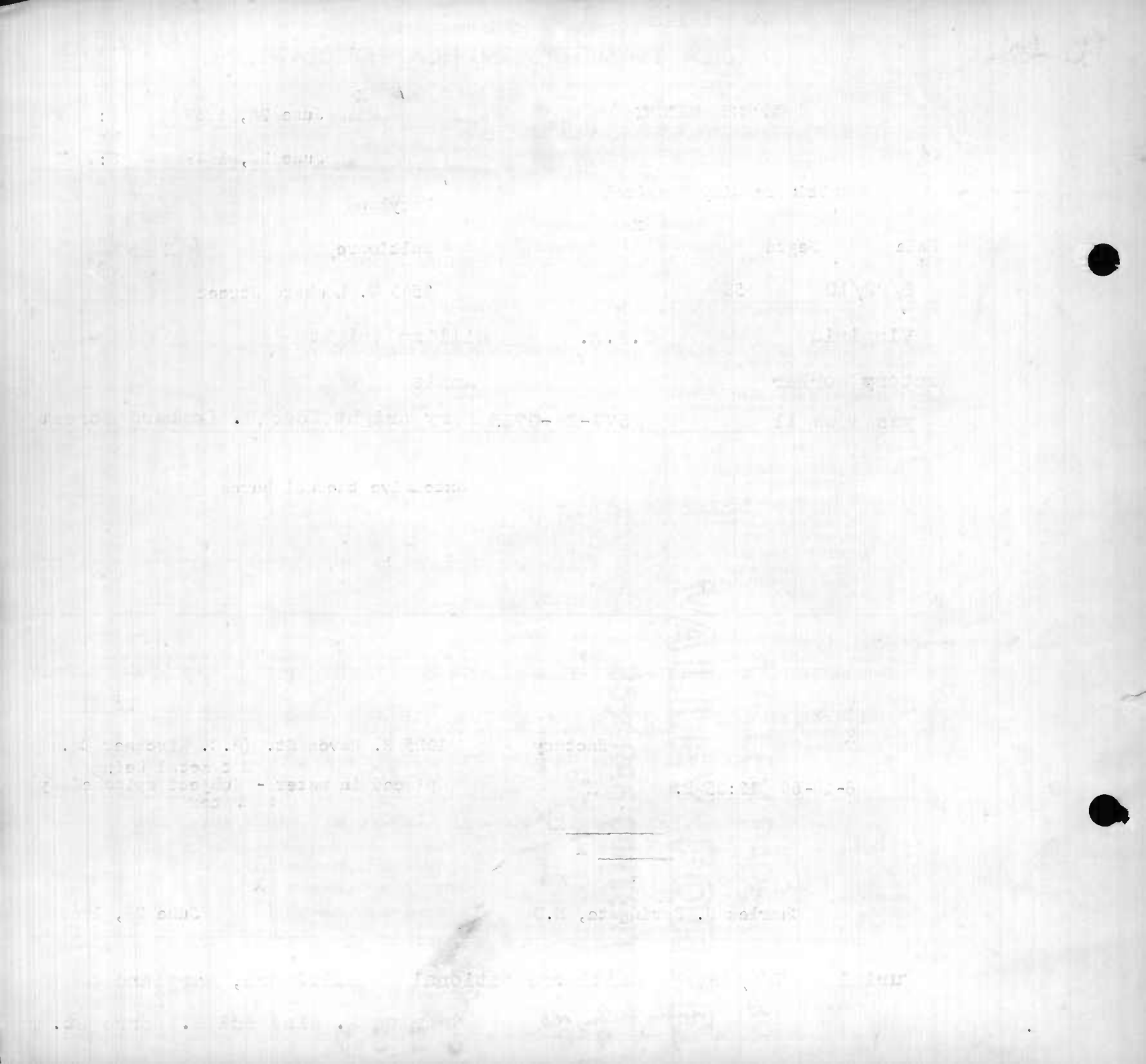


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE WRIGHT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 28, 1969 8:00 P M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year June 28, 1969 8:00 P M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 20-04	
9. DATE OF BIRTH 8/22/10		10. AGE (In years lost birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wright		14. MOTHER'S MAIDEN NAME Annie	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes ww 11		17. SOCIAL SECURITY NO. 577-24-0735	
18. INFORMANT Mary Wright		ADDRESS 2543 W. Lombard Street	
19. E924X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Extensive thermal burns (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1025 S. Haven St. (R.C. Kirchner Co.)		22D. TIME OF INJURY (APPROX.) 6-18-69 12:35 P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Hot metal being placed in water - Subject splashed by water	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 29, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/69	
24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR E. J. Barber, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELVER LEE INGRAM		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 27, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2029 Brunt St.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1969 11:30 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-23-09		10. AGE (In years lost birthday) 59	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Box E. Ingram		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT Jo Ethel Harris * same * daughter	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-69	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR E. Faber, M.D.	
25C. FUNERAL DIRECTOR Kelson F.H.		25D. ADDRESS 1348 N. Calhoun St.	

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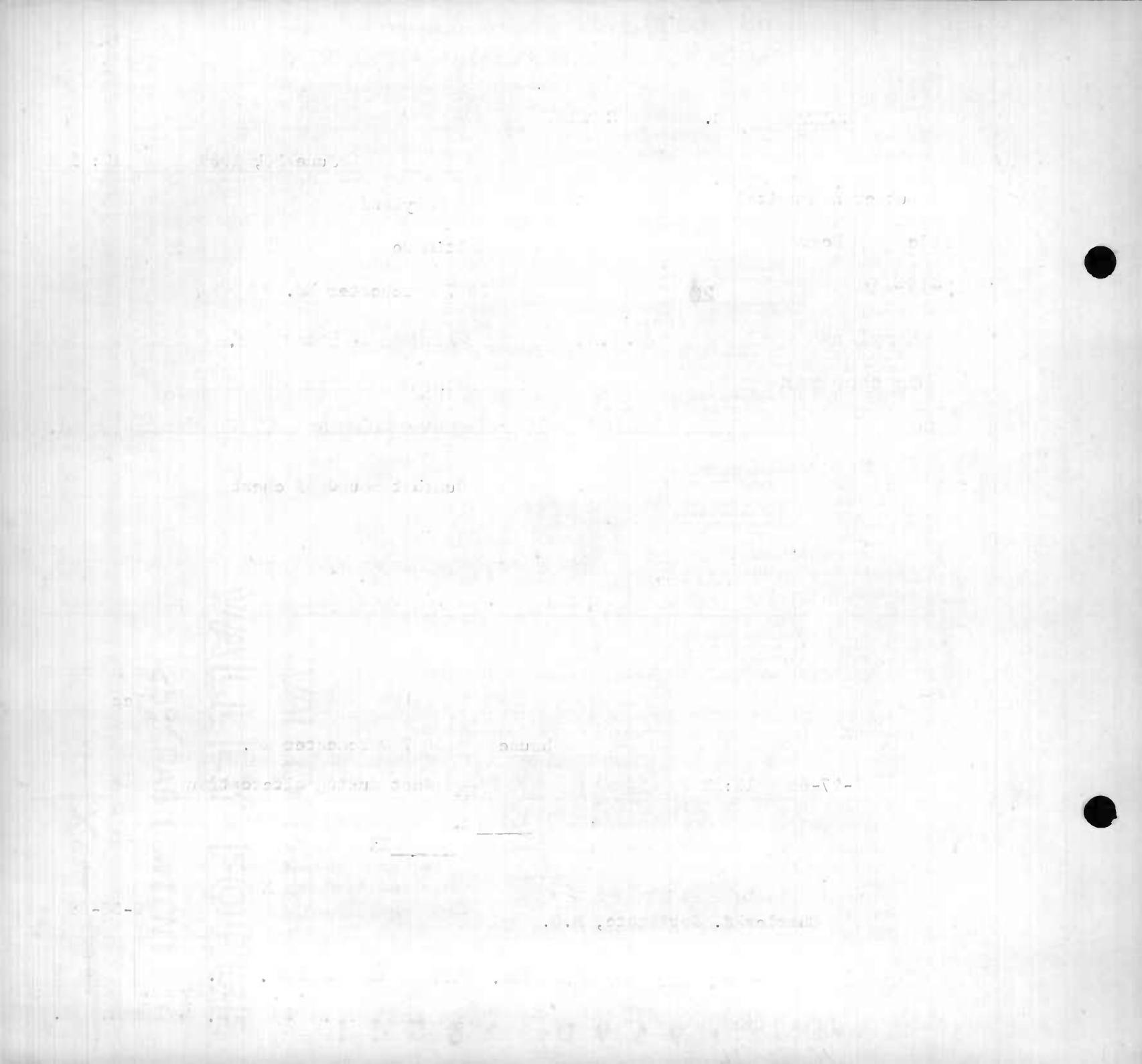
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLINTON C. COLEMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1969 12:05 A.M.	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5-11-49		10. AGE (In years lost birthday) 20 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) longshoreman		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 216527439	
18. INFORMANT Geneva Coleman		ADDRESS 4732 Wakefield Rd.	
19. CAUSE OF DEATH E96SX1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22D. TIME OF INJURY (APPROX.) 6-27-69 11:32 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3807 Dorchester Rd. 1510		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-28-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-69	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V.L. Bailey		25D. ADDRESS Kelson, F.H. 1348 N. Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6551</u>
BIRTH NO. <u>69 6551</u>		1. NAME OF DECEASED (Type or Print) <u>MONTGOMERY, ARTHUR</u>		
2. DATE AND HOUR OF DEATH <u>6 26 69</u> <u>10:25 P</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1513</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>		6. RACE <u>Neg.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>4-17-28</u>		9. AGE (In years last birthday) <u>41</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Arthur Montgomery</u>		
14. MOTHER'S MAIDEN NAME <u>Teresa</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>218227834</u>		17. INFORMANT <u>Lillian Montgomery</u> ADDRESS <u>same</u>		
18. CAUSE OF DEATH <u>320.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u> <u>SPINAL MENINGITIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5 days(?)</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> 19 <u>69</u> to <u>6/26</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/26</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Eric Juditz</u>		23B. DATE SIGNED <u>6/26/69</u>		23C. PHYSICIAN'S NAME (Type) <u>ERIC JUDITZ</u>
23D. ADDRESS <u>SINAI HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>7-1-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Haber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Kelson F. H.</u> ADDRESS <u>1348 N. Calhoun St.</u>



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6552

BIRTH NO. 64-05969

1. NAME OF DECEASED (Type or Print) WILMA L. FLETCHER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 27, 1969 Hour 11:59 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 27, 1969 Hour 11:59 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/7/64		10. AGE (In years lost birthday) 5 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Joyce E. Wilkins		18. INFORMANT Mr. Wm. L. Fletcher	
19. E 814.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Central Ave. South of Chase Street		22F. HOW DID INJURY OCCUR? Pedestrian struck by truck	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) June 27, 1969 11:48		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/27/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/69	
24C. NAME OF CEMETERY or CREMATORY Carver Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm. C. March		ADDRESS 928 E. North Ave.	

3/1/64

Barryland

William A. Wheeler

Joyce E. Wilkins

Mr. Wm. L. Fletcher 1701 Madison St.

Handwritten signature

Barryland

Barryland

3/1/64

Barryland

Mr. E. H. Hatcher 228 N. North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 6553		CERTIFICATE OF DEATH		69 6553	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Catherine Morris</i>				2. DATE AND HOUR OF DEATH <i>June 27, 1969 11:20 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>				Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 914 N. Bradford Street					
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/11	9. AGE (In years lost birthday) 57	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Greenville N. Carolina</i>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Arthur Gorham</i>			14. MOTHER'S MAIDEN NAME <i>Jennie F. Allen</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Norris</i>		ADDRESS		
18. <i>430.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Subarachnoid Hemorrhage</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Multiple aneurysms circle of Willis</i> (B) <i>Life</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hr.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>June 26 1969</i> to <i>June 27 1969</i> that (1) (we) last saw the deceased alive on <i>June 27 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Paul Redstone M.D.</i>						23B. DATE SIGNED <i>6-27-69</i>			
23C. PHYSICIAN'S NAME (Type) Paul Redstone, M.D.						23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<i>Burial</i>		<i>July 1, 1969</i>		<i>Mt Calvary Cem.</i>		<i>A. A. County Md.</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<i>JUN 30 1969</i>		<i>Paul E. Taylor M.D.</i>		<i>Joseph E. Glendon</i>		<i>1129 N. Carolina</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6554
BIRTH NO. 69 6554		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DONALD P. WHITCOMB		2. DATE AND HOUR OF DEATH JUNE 28 1969 4:05 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) SINAI Hosp BALTO		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/02		9. AGE (In years last birthday) 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) PIESKILLE, PA.	
13. FATHER'S NAME RICHARD WHITCOMB		14. MOTHER'S MAIDEN NAME RUTH FUNKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 218-03-1758		17. INFORMANT HA. Mrs. Ruth A. Hall	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) GI HEMORRHAGE		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UGI ulcer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs.	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. EMPHYSEMA				CHRONIC (1965)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC					
19A. DATE OF OPERATION 6/28		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/28 19 69 to 6/28 19 69 and that (we) lost saw the deceased alive on 6/28 19 69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stuart H. Spielman M.D.		23B. DATE SIGNED 6/28/69		23C. PHYSICIAN'S NAME (Type) STUART H. SPIELMAN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2, 1969		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR John E. Baker, M.D.		25C. FUNERAL DIRECTOR Frank H. Powell	

7/2/69 - Correction form from funeral director.

lfc

FUNERAL DIRECTOR: IMPORTANT

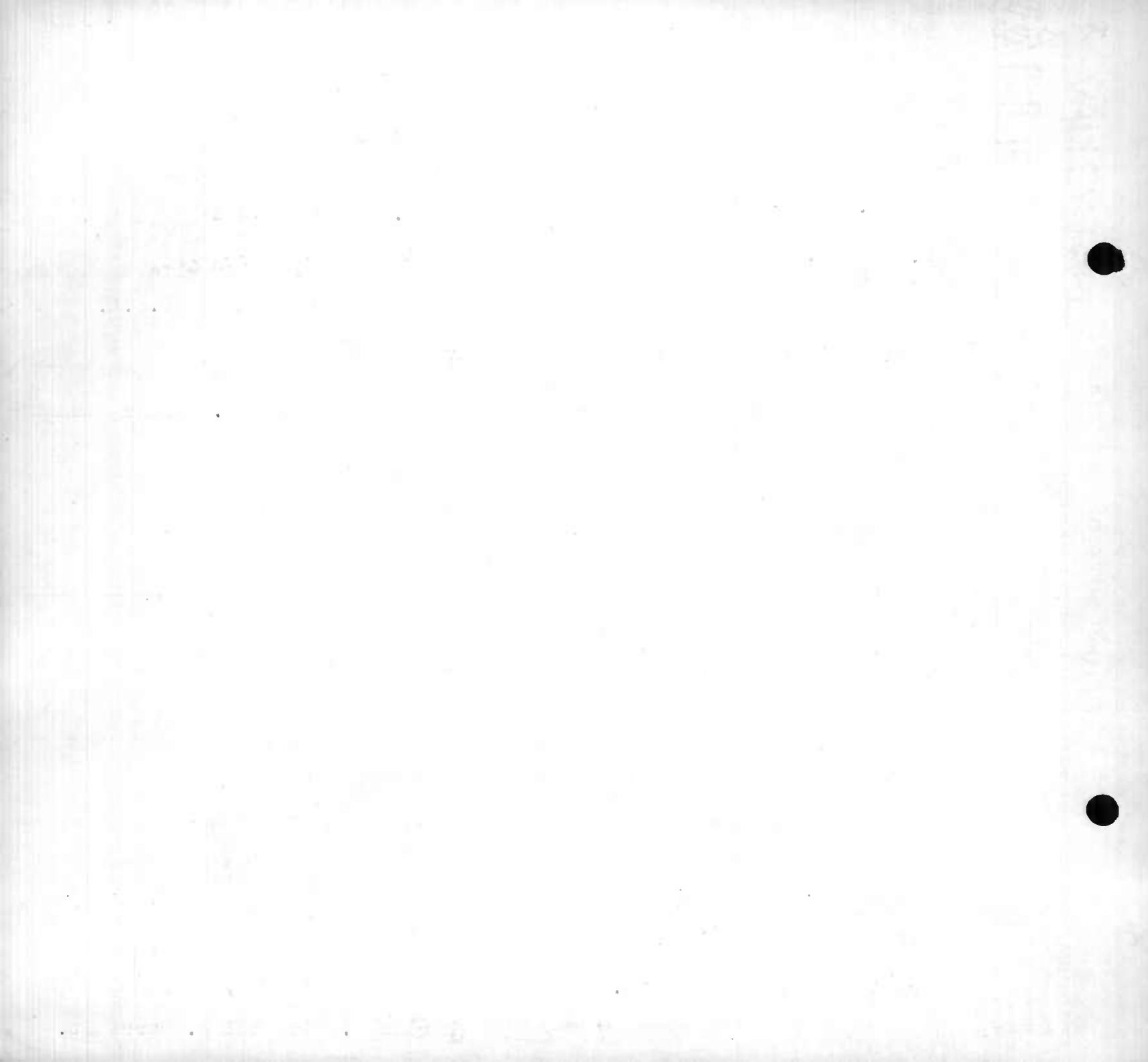
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6555

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lillie Reynolds		2. DATE AND HOUR OF DEATH 6/28/69 4:00 P M.																	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1402																	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 422 W. Mosher Street		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
5. SEX F.		6. RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>																	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4/5/91 9. AGE (In years last birthday) 78																	
13. FATHER'S NAME Wash Simms		14. MOTHER'S MAIDEN NAME Emelyn Gross		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.																	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mildred Evans ADDRESS 422 W. Mosher Street																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">1B. 410.0 I CAUSE OF DEATH</td> <td colspan="2">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td colspan="2">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</td> <td colspan="2">2 days</td> </tr> <tr> <td colspan="2">ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</td> <td colspan="2">3 mos</td> </tr> <tr> <td colspan="2">II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</td> <td colspan="2"></td> </tr> </table>						1B. 410.0 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		2 days		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		3 mos		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
1B. 410.0 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		2 days																			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		3 mos																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).																					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)																	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?																	
22. I certify that (I) (this hospital) attended the deceased from 4-11-69 19 to 6-28-69 19, that (I) (we) last saw the deceased alive on 6-28-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																					
23A. SIGNATURE Franklin Phillips M.D. DEGREE				23B. DATE SIGNED 6/30/69																	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips M.D.		23D. ADDRESS																			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn																	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State) Md.																			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.																	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6556

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LEROY ELSLEY

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

June 27, 1969

9:10 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1029 Ashburton

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

June 27, 1969

9:10 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1606

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5/24/03

10. AGE (In years last birthday)

66 69

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1029 Ashburton

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm. ELSLEY

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

14B. KIND OF BUSINESS OR INDUSTRY

J. H. Hosp.

15. MOTHER'S MAIDEN NAME

Addie GILES

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

219-01-8712

18. INFORMANT

MARGARET Pindell HILL

ADDRESS

19.

412.4 I

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/69

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

7/30/69

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

A. A. County, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUN 30 1969

Robert E. Fairbank, Jr.

Joseph M. Locks, Jr. 1304 N. Central Ave.

(1903)

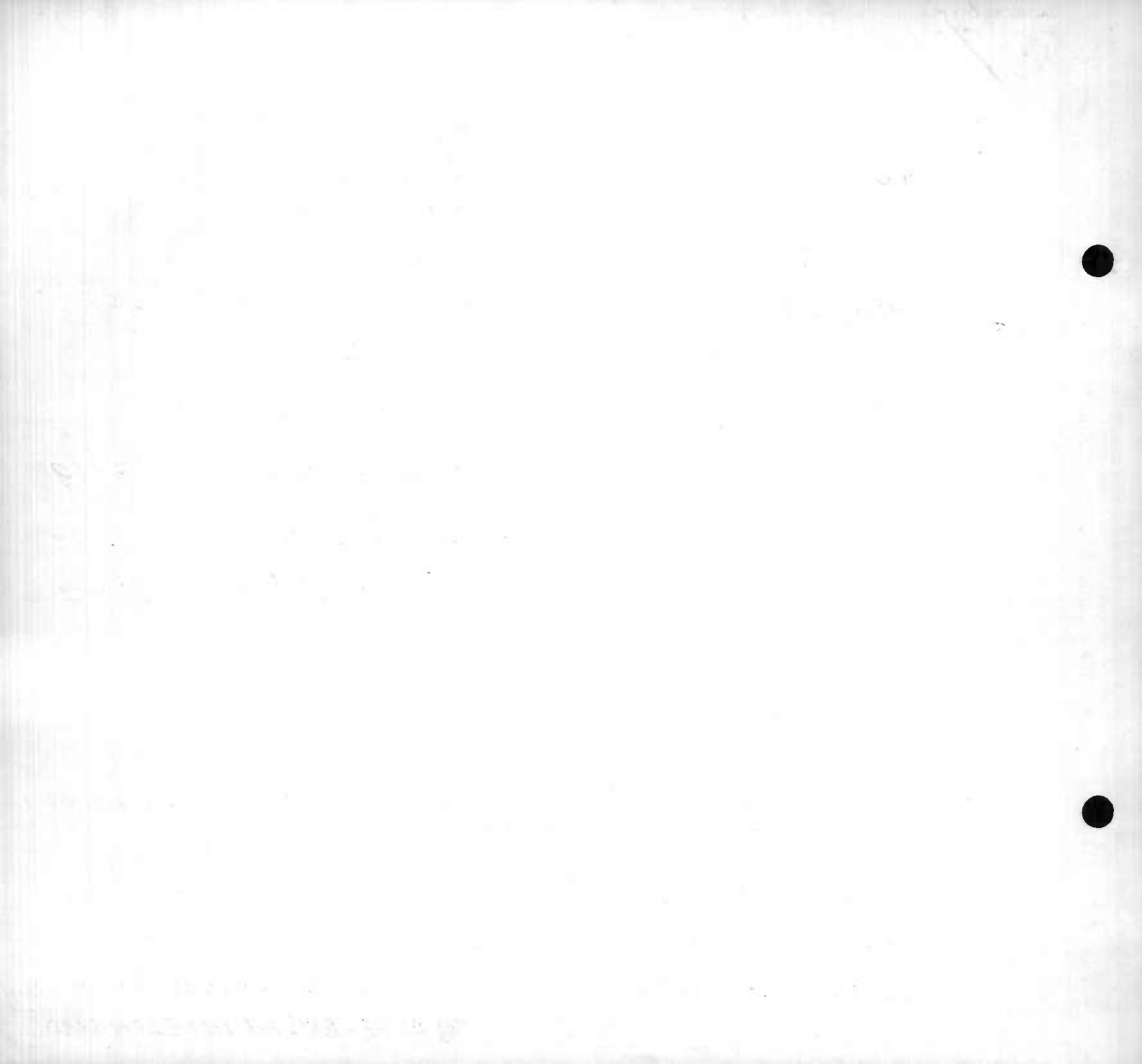
7/1/69 - Birth certificate of deceased - B-35270 shows date of birth:
May 27, 1903.

LBC.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6557	
BIRTH NO. N-610		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NORFI, ROSE V.			2. DATE AND HOUR OF DEATH 6-29-69 2 AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 604		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing Home			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 5 N. CHAPEL ST.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-02	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) ST MARY'S COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNK			14. MOTHER'S MAIDEN NAME ROSE QUADE.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	17. INFORMANT Bolton Hill N.H. 1400 JOHN ST.		
18. 1990 I CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer metastasis		3/69
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Portal Hypertension		3/69
			(C) Hypertensive C.V. disease		years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/6 1969 to 6/29 1969 , that (I) (we) last saw the deceased alive on 6/29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED 6/29/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MAEHT MD DEGREE				23D. ADDRESS 2 E. READ ST BALTIMORE 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL JUN 30 1969 MEADOWRIDGE MEMORIAL PARK		DORSEY (WASH BLVD) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
1969		1969		THE DYER & BROS INC 1800 E LOMBARD ST	



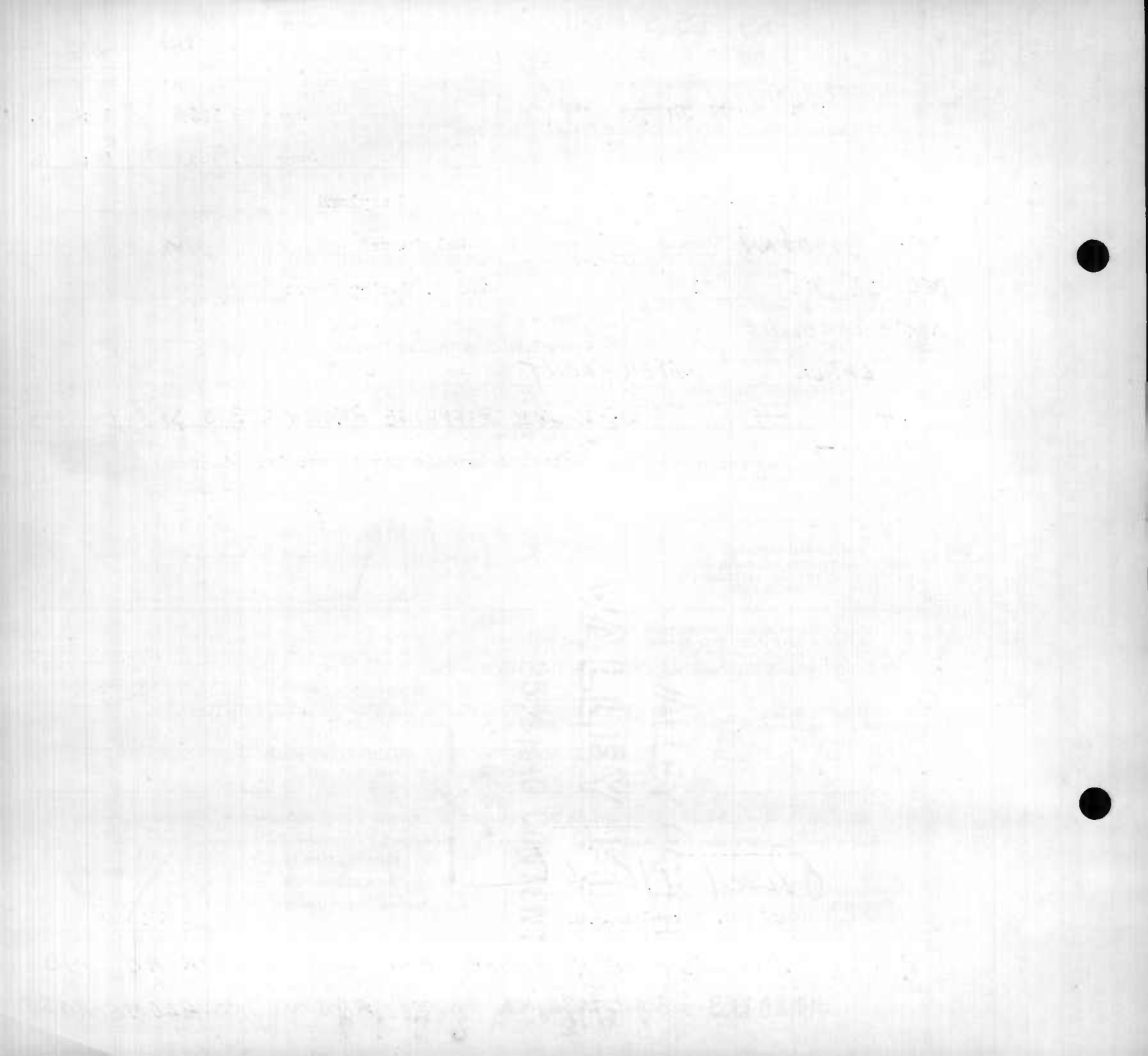
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6558

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JOHN BROWN JR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1969 10:20 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1969 10:20 A.	
6. SEX Male		7. RACE INDIAN	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH DEC. 25 1905		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINE		12. CITIZEN OF WHAT COUNTRY? USA.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		14B. KIND OF BUSINESS OR INDUSTRY WATER FRONT	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 205-20-4826	
18. INFORMANT JOSEPHINE BROWN		ADDRESS 203 S SPRING COURT	
19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 2 1969	
24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM.		24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR DIPREL BROS INC		ADDRESS 1800 E LOMBARD ST	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6559

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIE CANDIE

2. DATE AND HOUR OF DEATH

7 30 PM 6/26/69

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSP.
BALTIMORE, MD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

704 E. BIDDLE ST.

5. SEX

M

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-23-1913

9. AGE (in years)

56

If Under 1 Yr. Months: Days: Hours: Min.

If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shoe Repairman

10B. KIND OF BUSINESS OR INDUSTRY

Shoe Repair

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Candie

14. MOTHER'S MAIDEN NAME

Julia Edwards

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

No

--

16. SOCIAL SECURITY NO.

217-09-0866

17. INFORMANT

Jessie Hitchcock Phil. 31, Pa.

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE ACUTE RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 DAYS

(B) CLOSTRIDIAL WELCHII SEPSIS
DUE TO, OR AS A CONSEQUENCE OF:

5 DAYS

(C) SCROTAL ABSCESS

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

6/26/69

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

SCROTAL-PERINEAL ABSCESS

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT OR UNDERLYING CAUSE OF DEATH (Specify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/19/69 to 6/26/69 that (I) (we) last saw the deceased alive on 6/26/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jerome L. Rubin

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/26/69

23C. PHYSICIAN'S NAME (Type)

JEROME L. RUBIN

DEGREE

23D. ADDRESS

JOHNS HOPKINS HOSP

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-7-1-69

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION

A.A. Co., Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

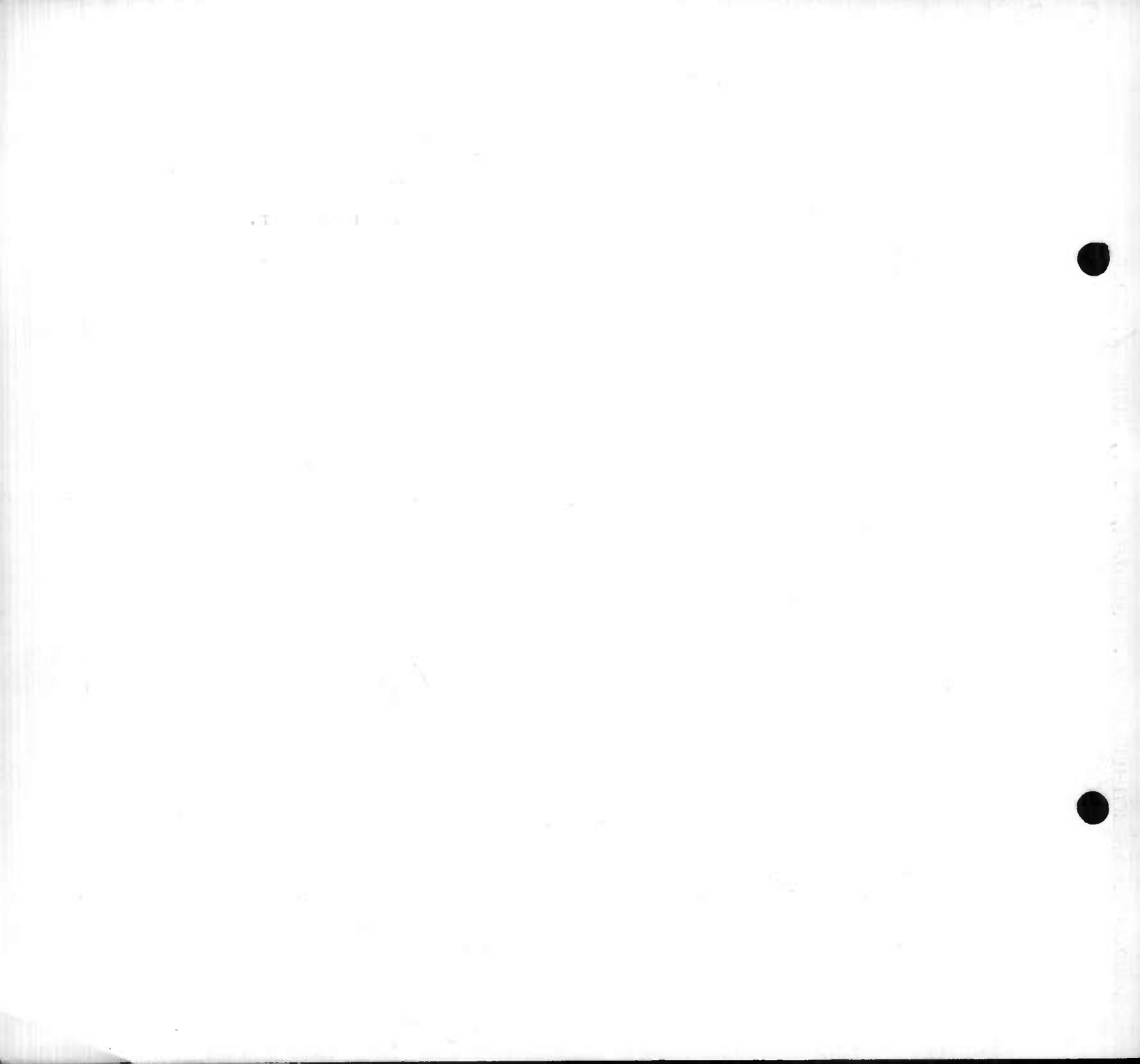
25B. NAME OF REGISTRAR

Robert E. Jones, Jr.

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr. 1735 Harford Ave

ADDRESS



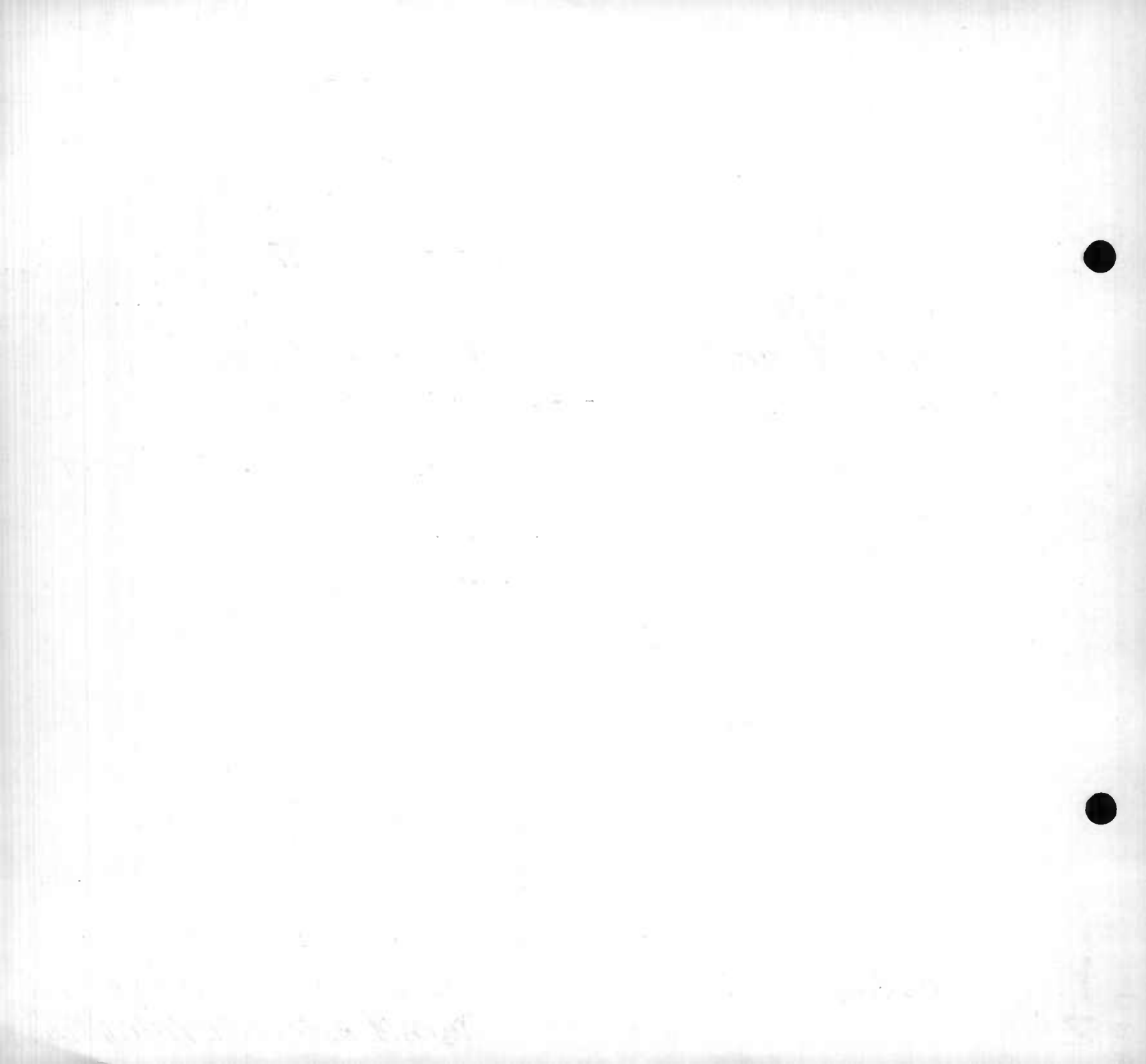
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6560

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6566

BIRTH NO. 5000		1. NAME OF DECEASED (Type or Print) AUGUSTA GRAY		2. DATE AND HOUR OF DEATH 6-29-69 11:15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING CENTER 90				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1703 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER III4 MY RTLE AVE.	
5. SEX F	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-92	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GORDONSVILLE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HAROLD DAVIS			14. MOTHER'S MAIDEN NAME MARY NICHOLAS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-30-6288	17. INFORMANT ADMISSION RECORD		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) I Hemiplegia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hemiplegia B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis C) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/69 years years					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 4/10 1969 to 6/29 1969 that (I) (we) last saw the deceased alive on 6/29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED 6/30/69 23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD 23D. ADDRESS 2 E Real St Baltimore 21202 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 7/3/69 24C. NAME OF CEMETERY or CREMATORY ARBON'S MEMORIAL PK 24D. LOCATION (City, town, or county) (State) SOUTHER SPRINGFIELD MD 25A. DATE REC'D BY HEALTH DEPT. JUN 30 1969 25B. NAME OF REGISTRAR Robert E. Fisher MD 25C. FUNERAL DIRECTOR ADDRESS DORIS M. G. LOVER 1701 N. B. ST BALTIMORE					



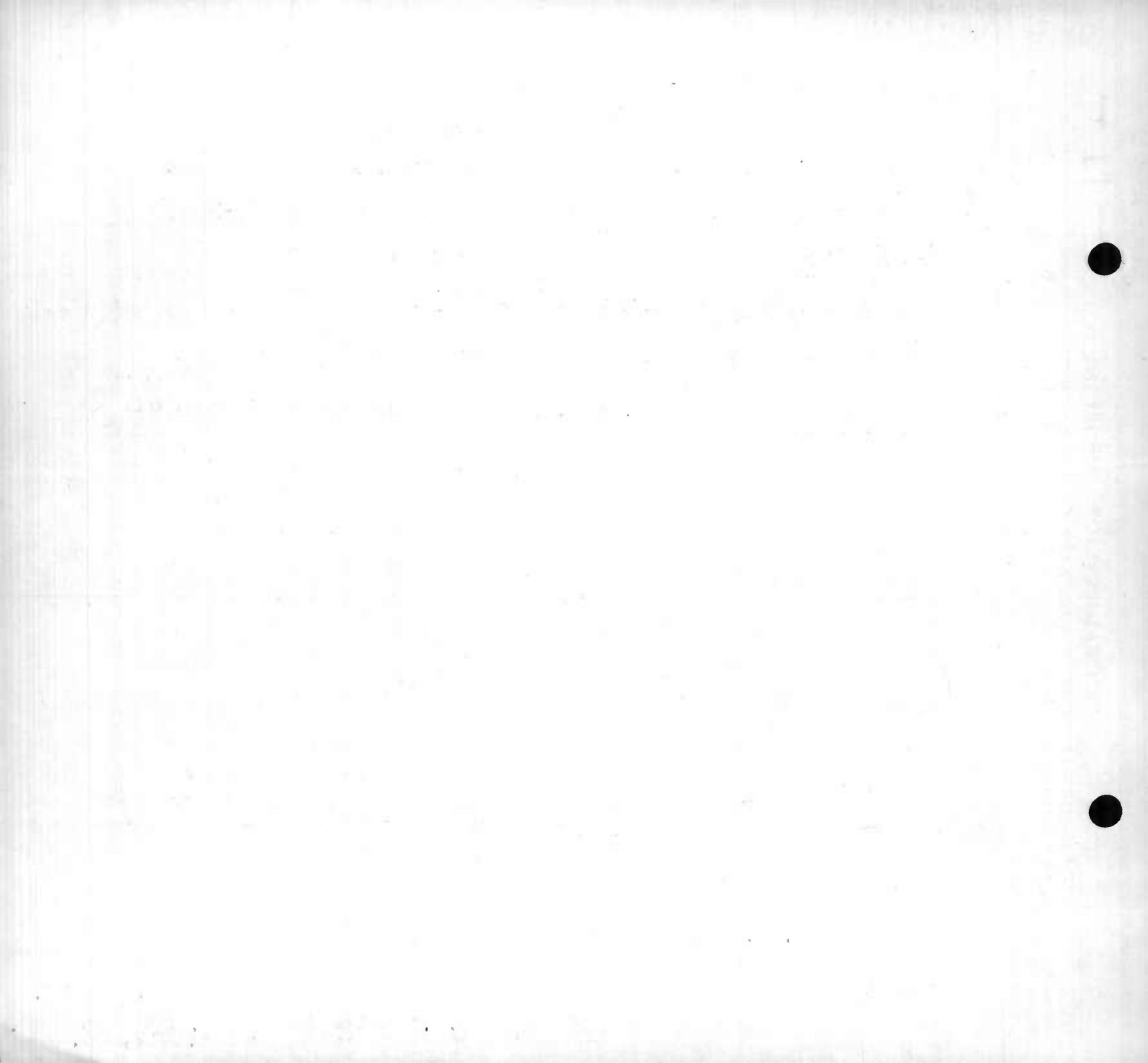
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6561 CERTIFICATE OF DEATH

REG. NO. 69 6561

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH JOHN HEINDL, JR.		2. DATE AND HOUR OF DEATH 6/28/69 4:45p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 901	
FULL NAME OF HOSPITAL OR INSTITUTION 3935 FRISBY STREET		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE, MD. 21218		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEC. ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY UTILITY		8. DATE OF BIRTH 8-19-11	
13. FATHER'S NAME JOSEPH JOHN HEINDL, JR.		14. MOTHER'S MAIDEN NAME MARGARET B. SMITH		9. AGE (In years last birthday) 57 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-2132		17. INFORMANT MRS. PHYLLIS T. HEINDL (SAME)	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CEPHAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral hemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive cardiovascular disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 5 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1967 to June 28 1969 , that (I) (was) last saw the deceased alive on June 21 1969 and that in (my) (best) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (not) view the body after death.					
23A. SIGNATURE A. Allan Spier				23B. DATE SIGNED 6/28/69	
23C. PHYSICIAN'S NAME (Type) Dr. A. Allan Spier				23D. ADDRESS 1501 Pentridge Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/69		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Baltimore County, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969			
25B. NAME OF REGISTRAR Robert E. Dube, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto 21212, Md.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGINA PACIARELLA

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

June 29, 1969

9:45 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

137 N. Ellwood Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 29, 1969

9:45 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

601

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4/5/1898

10. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

137 N. Ellwood Avenue

11. BIRTHPLACE (State or foreign country)

Rome, Italy

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Dr. Joseph Paciarelli

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Teacher

14B. KIND OF BUSINESS OR INDUSTRY

Education

15. MOTHER'S MAIDEN NAME

Josephine Piacentini

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

214-40-8325

18. INFORMANT

ADDRESS

Joseph Cullotta, 1922 E. Belvedere Av

19.

412.41256.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic Cardiovascular Disease

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes Mellitus

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/2/69

24C. NAME OF CEMETERY or CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1969

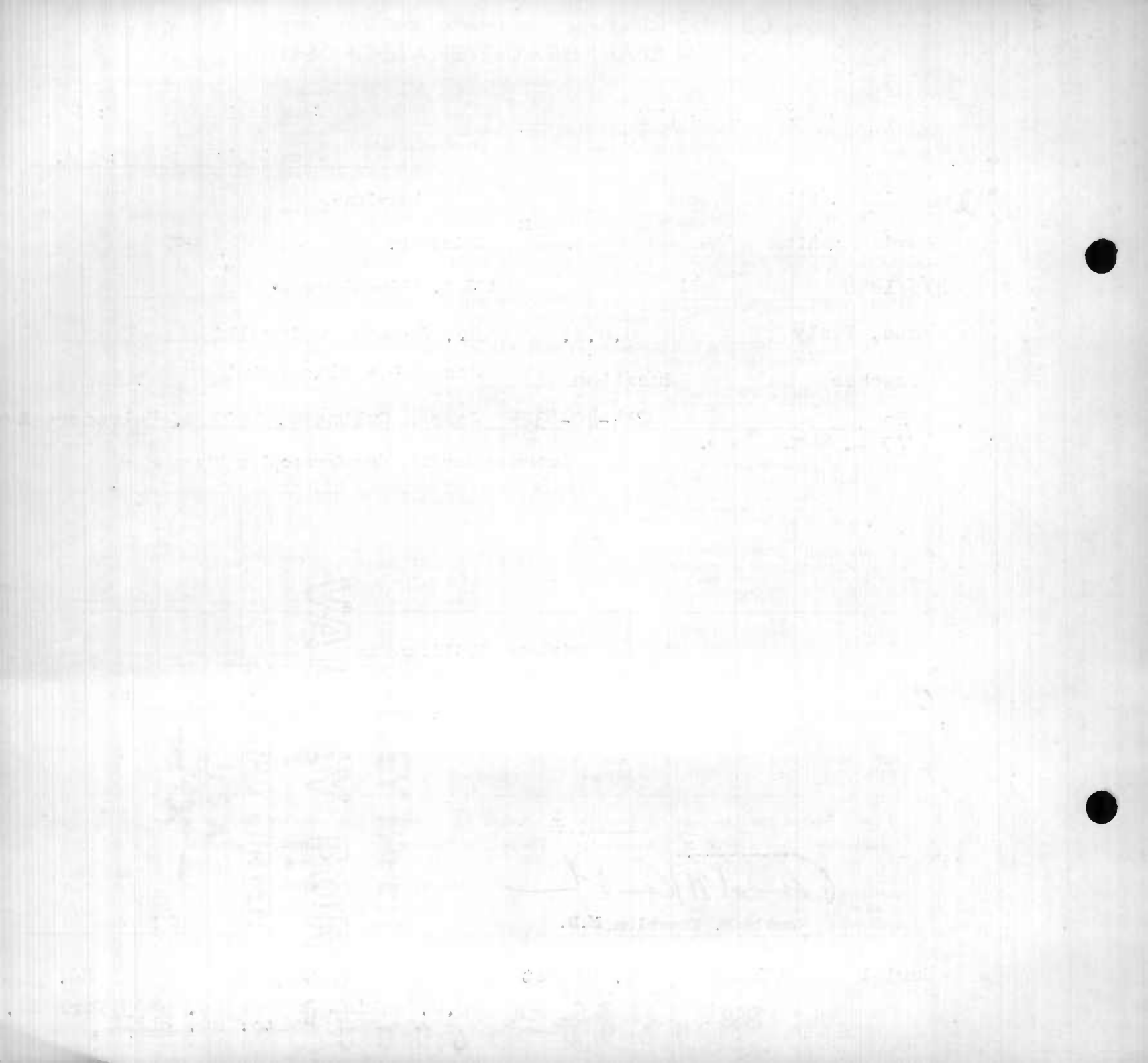
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. Md. 21212

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

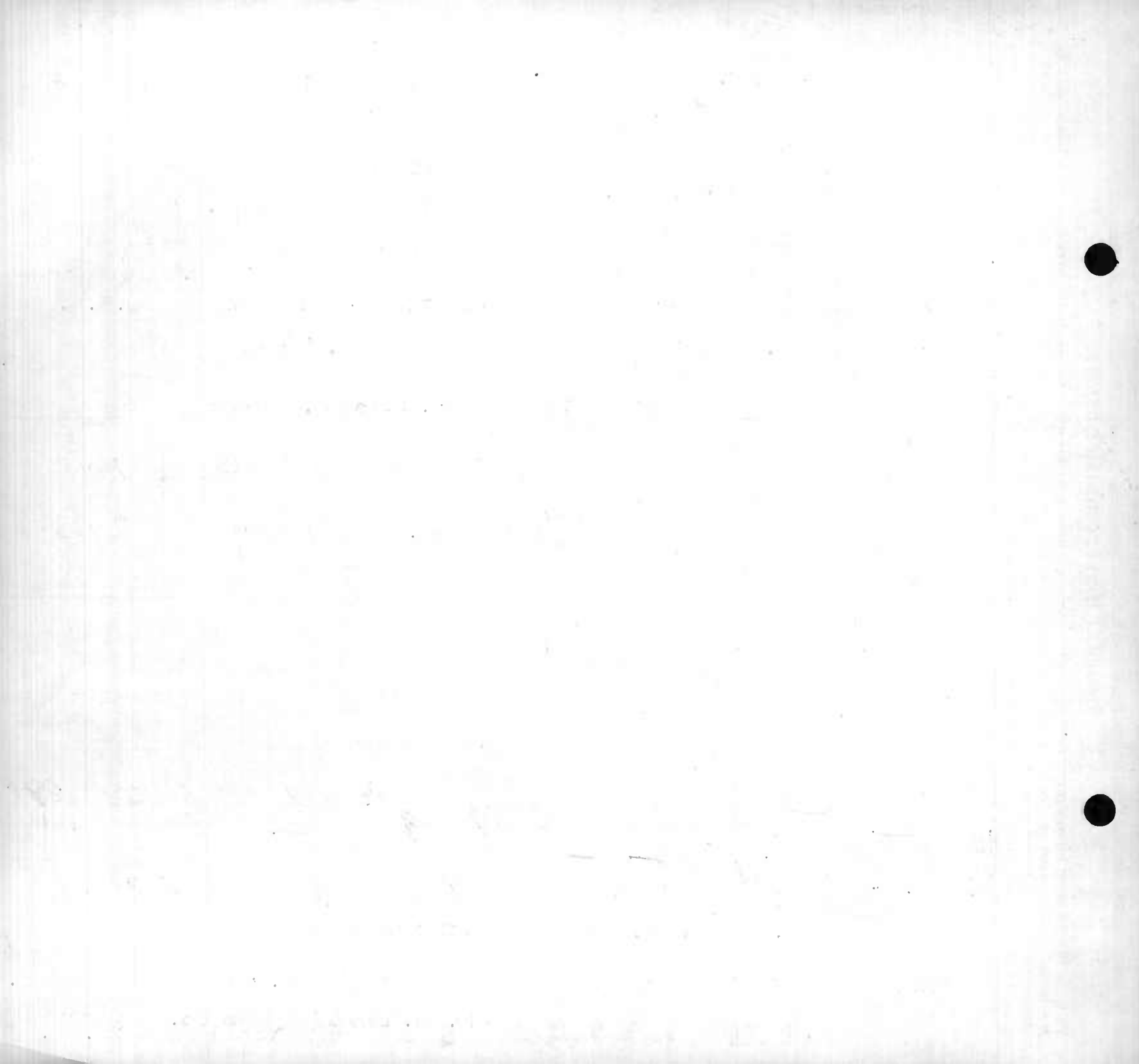
REG. NO. 69 6563

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jeannette Cromwell Janvier		6-29-1969 1645 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 218 Ridgewood Inc.			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 111 Deepdene Road		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-1906	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland Baltimore County,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Martin J. Cromwell			14. MOTHER'S MAIDEN NAME Nettie Jenkins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-4776		17. INFORMANT Mr. M. John Cromwell Brightside Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Coronary Artery Disease</i> <i>Hypertension</i> <i>Myocardial Infarction</i> <i>Chronic Vascular Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 yrs</i> <i>4-6 months</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE OF DEATH (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 1958</i> to <i>June 29 1969</i> , that (I) (we) last saw the deceased alive on <i>June 29 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. H. Woody</i>			23B. DATE SIGNED 6-30-69		
23C. PHYSICIAN'S NAME (Type) Dr. W. H. Woody			23D. ADDRESS 1403 Park Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-1969		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 3905 York Road Balto., Md. 21212	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6564
BIRTH NO.		69 6564		
1. NAME OF DECEASED (Type or Print)		Evelyn B. Karch		2. DATE AND HOUR OF DEATH 6-28-1969 6¹⁰ A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 4407 Loch Raven Blvd.		A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1896
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Hughsville, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Clarence S. West		14. MOTHER'S MAIDEN NAME Katherine E. Powell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-7886	17. INFORMANT Mrs. Hazel K. Barrett	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CANCER-METASTASIS- (B) CARCINOMA-OVARY DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR. 2 YRS.
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7-10 1968 to 6-28 1969 , that (I) (we) lost saw the deceased alive on 6-27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Anthony F. Carozza		23B. DATE SIGNED 6-30-69		23C. PHYSICIAN'S NAME (Type) Dr. Anthony F. Carozza
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 6-30-1969		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Mausoleum
24D. LOCATION Balto. County,		24E. LOCATION (City, town, or county) (State) Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR R. E. J. J. J.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.
25D. ADDRESS 3905 York Road		25E. ADDRESS 21212 Balto. Md.		

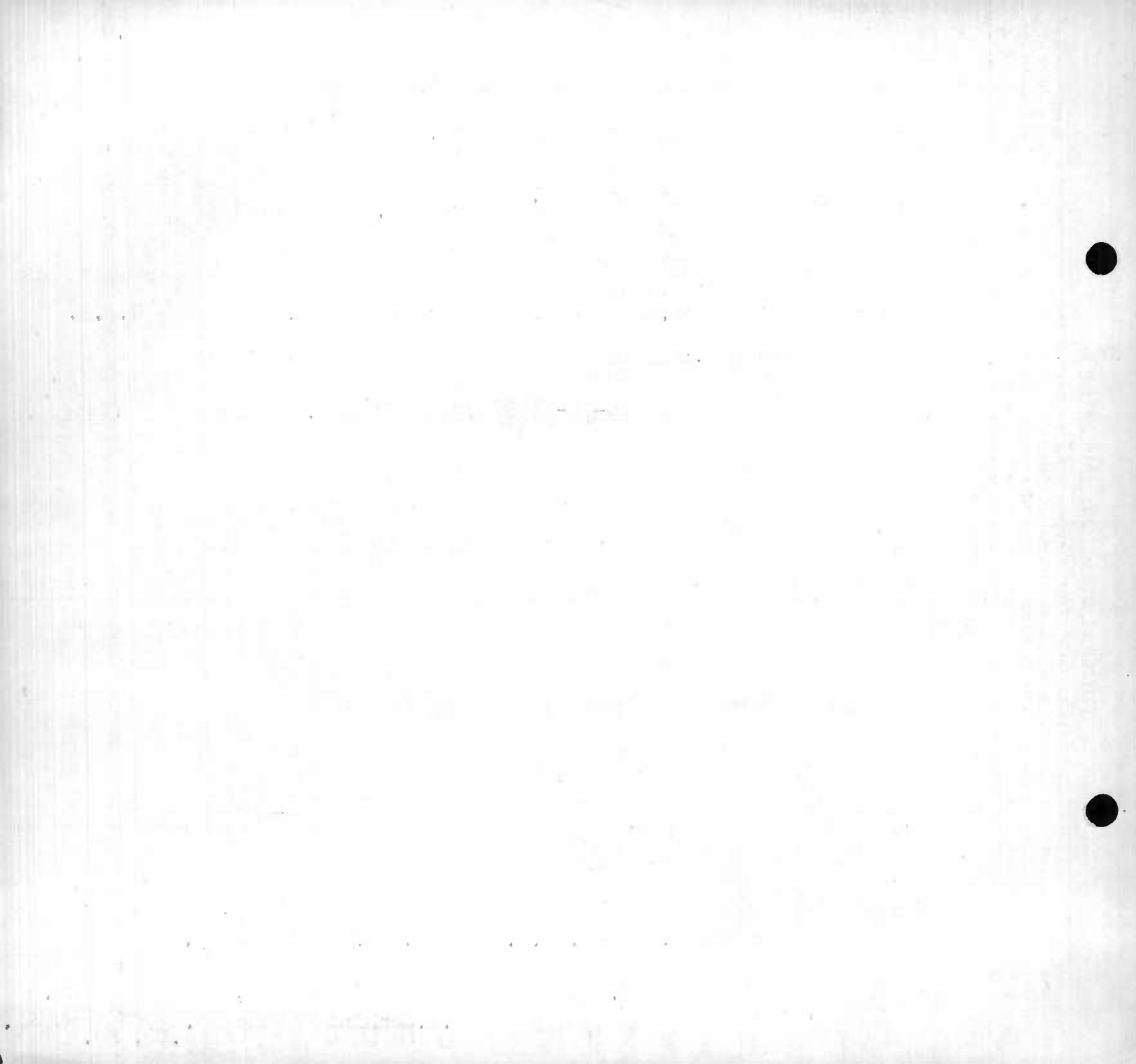


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6565 BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH
 REG. NO. 69 6565

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Caroline Battee Mullikin		6/26/69 1 6:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital				A. STATE Md.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 726 St. Johns Road	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/25/1890	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Teacher		10B. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME William Lawrence Mullikin		14. MOTHER'S MAIDEN NAME Sophia Ridgely Battee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-5293T		17. INFORMANT Miss Edith B. Paterson	
				ADDRESS (Same)	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.0 I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (C) DUE TO, OR AS A CONSEQUENCE OF: Hypertension					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/21/43 19 to 6/26/69 19, that (I) (we) last saw the deceased alive on 6/26/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis W. Gluck M.D.				23B. DATE SIGNED 6/27/69	
23C. PHYSICIAN'S NAME (Type) Francis W. Gluck, M.D.				23D. ADDRESS 100 W. University Pkwy.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69		24C. NAME of CEMETERY or CREMATORY Mt. Olivet	
24D. LOCATION Baltimore,		24E. (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>69 6566</u>	
BIRTH NO. <u>69 6566</u>		1. NAME OF DECEASED (Type or Print) <u>SUSAN WHITTEN</u>		2. DATE AND HOUR OF DEATH <u>6/26/69</u> <u>345</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSP BALTIMORE MD 21201</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO. 21234</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>8507 A DEMPSTER CT.</u>		
5. SEX <u>F</u>	6. RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/69</u>	9. AGE (In years last birthday) <u>2</u>	10. Under 1 Yr. Months: <u>6</u> Days: <u>6</u> Hours: <u>00</u> Min. <u>00</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND (BALTO.)</u>	
13. FATHER'S NAME <u>THOMAS R. WHITTEN, JR</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA E. HALL</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>THOMAS R. WHITTEN, JR. (SAME)</u>	
18. <u>7468 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>CHD, CYANOTIC (HYPOPLASTIC LEFT HEART)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>TRISOMY 21 (BY CHROMOSOME STUDY)</u>			20. DATE OF OPERATION <u>5/23/69</u> 20A. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>EVALUATION OF CHD</u> 20B. AUTOPSY? (Yes or No) <u>—</u> 20C. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> <u>1969</u> to <u>6/26</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>6/26</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert L. Ginger</u>			23B. DATE SIGNED <u>6/26/69</u>		23C. PHYSICIAN'S NAME (Type) <u>ROBERT L. GINGER</u>
23D. ADDRESS <u>University Hospital</u>			23E. DEGREE <u>—</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley Mem. Grds, Timonium, Balto. Co. Md.</u>	
24D. LOCATION <u>BALTO. CO. MD.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		24F. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
24G. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		24H. ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>		24I. DATE <u>6/26/69</u>	

FUNERAL DIRECTOR: IMPORTANT

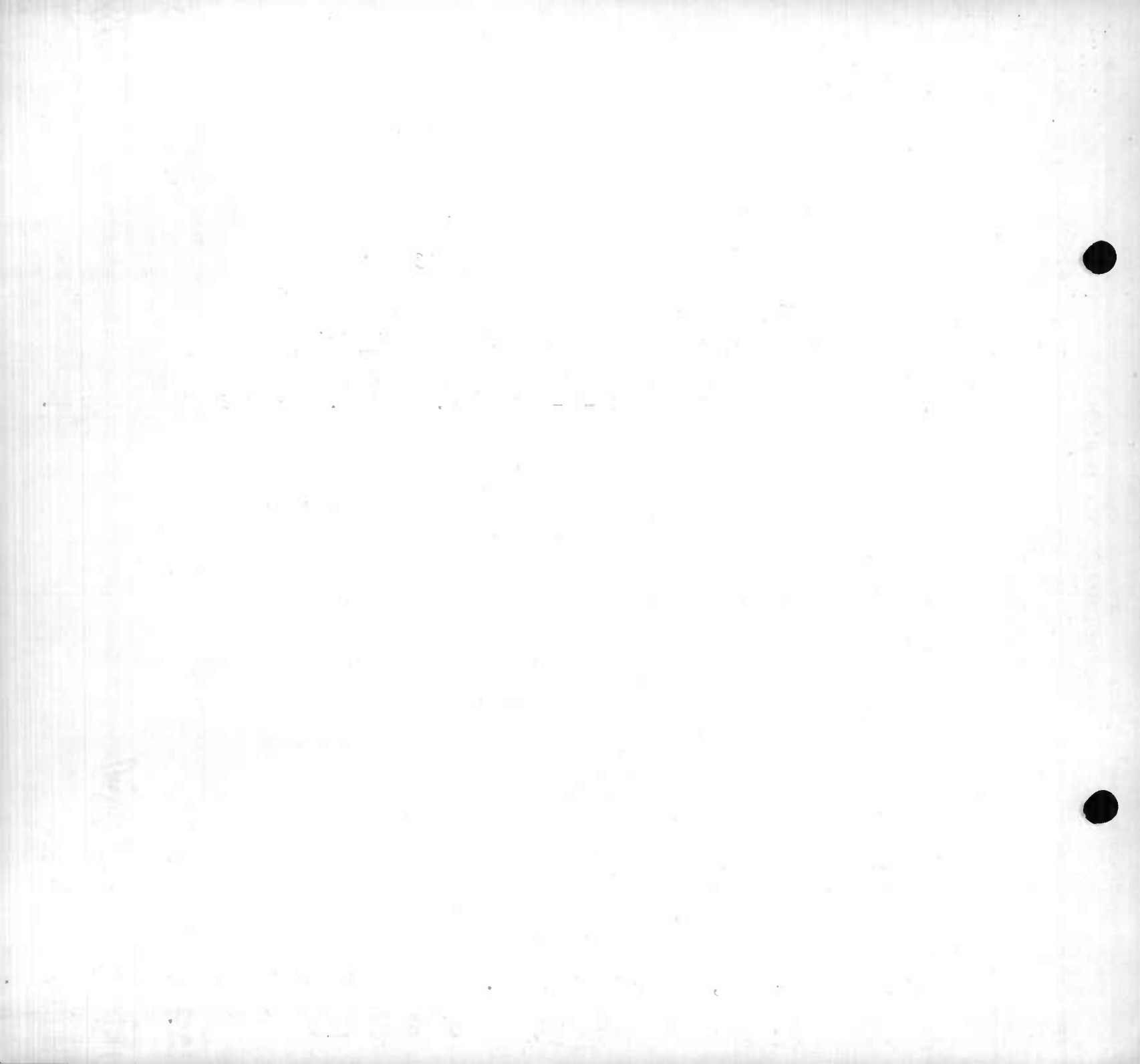
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 6567 CERTIFICATE OF DEATH

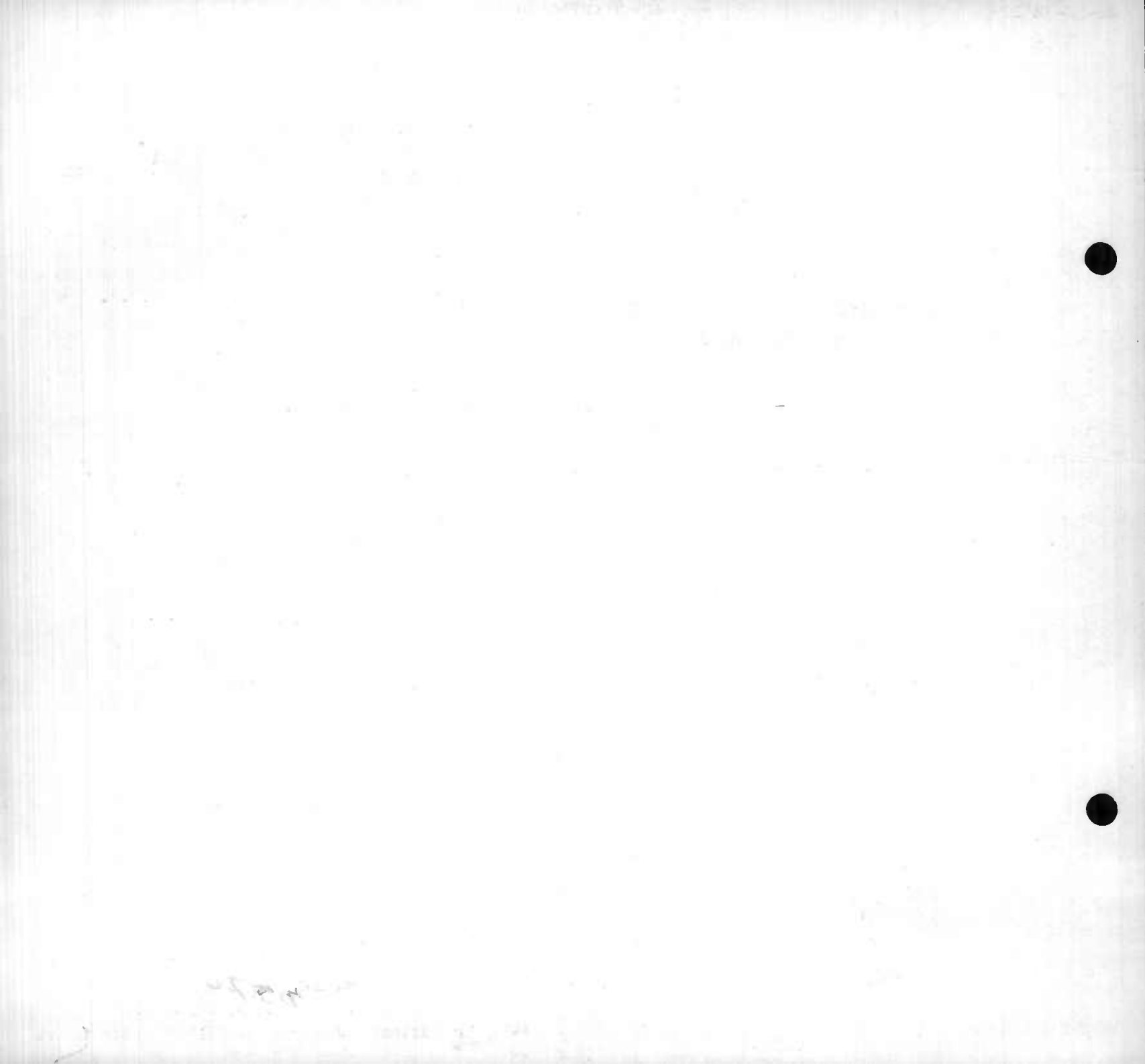
REG. NO. 69 6567

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William H. Gettings</u>		2. DATE AND HOUR OF DEATH <u>6-28-69</u> <u>8:35 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Balto md.</u> B. COUNTY <u>2717</u>		C. CITY OR TOWN <u>Balto</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Feb 23, 1903</u>		9. AGE (In years last birthday) <u>66</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry Business</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Gettings</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Crump)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-14-7443A</u>		17. INFORMANT ADDRESS <u>Mrs. Minnie L. Gettings 5402 Clover Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>162.1 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Lung with</u> <u>severe metastases and</u> <u>respiratory insufficiency</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>6-14-1969</u> to <u>6-28-1969</u> , that (I) (we) last saw the deceased alive on <u>6-28-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Chaweng Ongkasuwan M.D.</u>		23B. DATE SIGNED <u>6-28-69</u>		23C. PHYSICIAN'S NAME (Type) <u>CHAWENG ONGKASUWAN M.D.</u>	
23D. ADDRESS <u>Bon Secours Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 1, 69</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville Maryland Baltimore Co.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>	
24F. NAME OF REGISTRAR <u>John E. Barber, M.D.</u>		24G. FUNERAL DIRECTOR <u>Loring Byers</u>		24H. ADDRESS <u>8728 Liberty Rd. Randallstown</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6568	
BIRTH NO. C-425 69 6568					
1. NAME OF DECEASED (Type or Print) Anna Colligan			2. DATE AND HOUR OF DEATH June 27, 1969 4 ¹⁵ P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Essex 21221 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 24 GLENWOOD ROAD #21221		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME THEODORE RIES		
14. MOTHER'S MAIDEN NAME ANNA			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213 10 2570			17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 431.0 4250.9 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intra-cerebral Hemorrhage (B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: 7 yrs (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 day		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus Adult Onset					
19A. DATE OF OPERATION 6/24/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracerebral Hematoma		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? In Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 14, 1969 to June 27, 1969, that (I) (we) last saw the deceased alive on June 27, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce J. Nothmann MD				23B. DATE SIGNED 6/27/69	
23C. PHYSICIAN'S NAME (Type) Bruce J. Nothmann MD				23D. ADDRESS Baltimore City Hospitals	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/69		24C. NAME OF CEMETERY or CREMATORY Belair Memorial Gardens	
24D. LOCATION (City, town, or county) Belair, Maryland		24E. LOCATION (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL HOME Brydzinski Funeral Home 1407 Eastern Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6569	
69 6569				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HOMER C. South Sr.</u>		2. DATE AND HOUR OF DEATH <u>6/28/69</u> <u>5:25</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY Hosp. Inc.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-empl.</u>		8. DATE OF BIRTH <u>11/3/98</u> 9. AGE (In years lost birthday) <u>70</u>	
13. FATHER'S NAME <u>JAMES South.</u>		14. MOTHER'S MAIDEN NAME <u>MARY ?</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-3030</u>		17. INFORMANT <u>Mrs. Mae South</u> ADDRESS <u>same as #4</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>CORONARY ARTERY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF:	
				(C) <u>ATHEROSCLEROTIC HEART DISEASE</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC RENAL FAILURE</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>H</u> (this hospital) attended the deceased from <u>6-22-1969</u> to <u>6-28-1969</u> that <u>H</u> (we) lost saw the deceased alive on <u>6-28-1969</u> and that <u>In (my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>H</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph Notarangelo M.D.</u>				23B. DATE SIGNED <u>6-28-1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH NOTARANGELO M.D.</u>		23D. ADDRESS <u>MERCY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-1-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Cem.</u>	
24D. LOCATION <u>Dorsey</u>		24E. LOCATION (City, town, or county) <u>Md</u>		24F. LOCATION (State) <u>Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>McCully-Booz, Fort Ave</u>	
25D. ADDRESS <u>21230</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 6570

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Smaltz, Andrew R.

2. DATE AND HOUR OF DEATH

6/27/69 4:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)St. Agnes Hospital
Caton & Wilkens Ave

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1932 Griffis Ave

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5/14/1901

9. AGE (In years
last birthday)

68

10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Guard

10B. KIND OF BUSINESS OR INDUSTRY

Globe Security Agency

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

(Unknown) Smaltz

14. MOTHER'S MAIDEN NAME

Ada (Unknown)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W I

16. SOCIAL
SECURITY NO.

235-12-1040

17. INFORMANT

ADDRESS

Mrs. Eliza E. Smaltz, 1932 Griffis Ave. 21230

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

one hour

Hemorrhage Cerebral left
Arteriosclerosis Generalized 5 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Cardiac Arrhythmia Rt Bundle Branch Block

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/27/69 19 to 6/27/69 19
that (I) (we) last saw the deceased alive on 6/27/69 19 and that (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/27/69

23C. PHYSICIAN'S
NAME (Type)

W E McGrath

23D. ADDRESS

St. Agnes Hosp Bal to 29th

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

7-1-1969

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1969

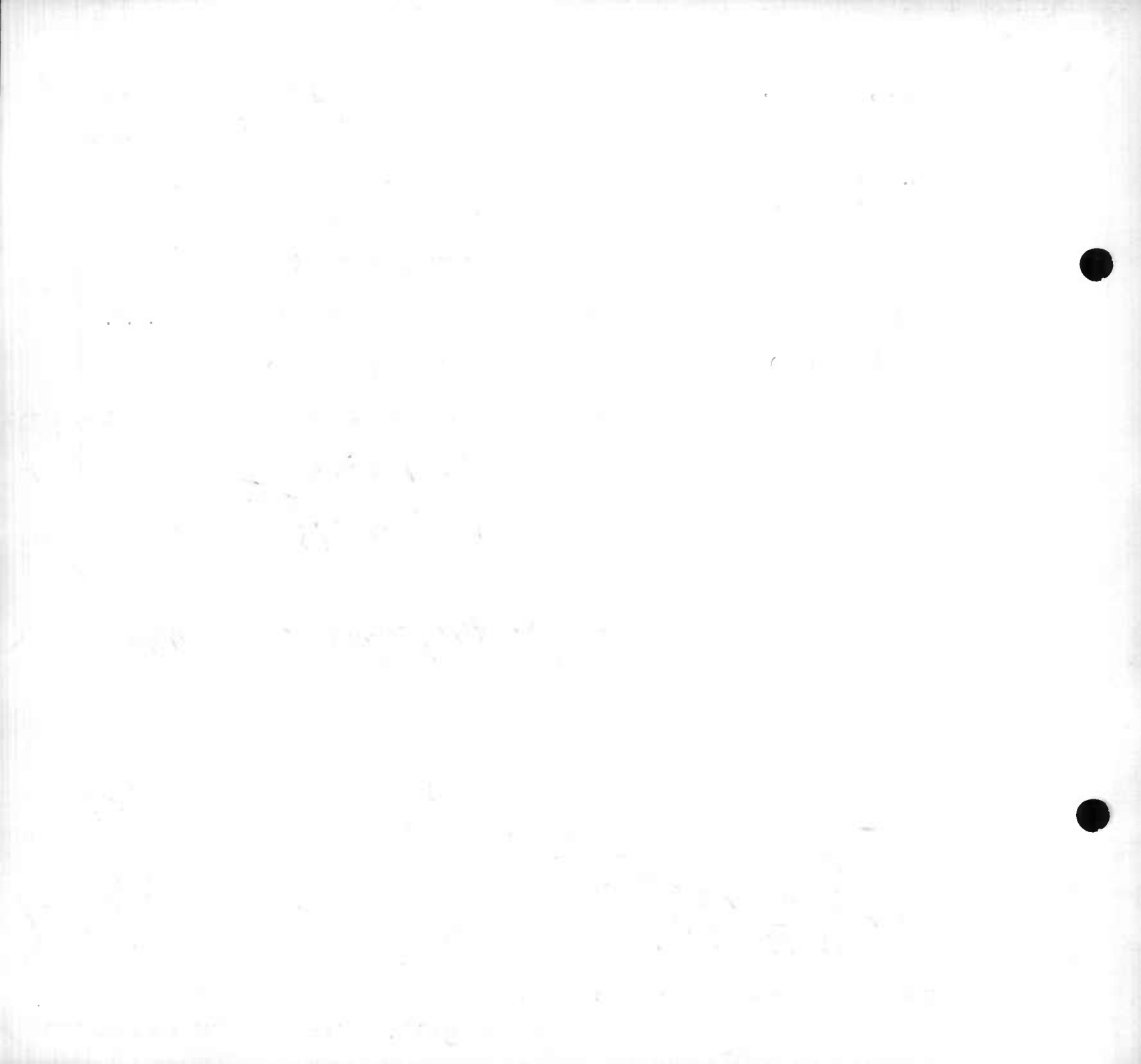
25B. NAME OF REGISTRAR

Howard E. Talbot, M.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6571

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT J. NASH

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

June 27, 1969

10:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 27, 1969

10:00 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

20-05

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

3-24-1921

10. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2222 Wilkens Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Howard Nash

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Florence Langlotz

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W II

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Beryl L. Nash, 2222 Wilkens Ave. 21223

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-1-1969

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229

0303
X

Robert M. White

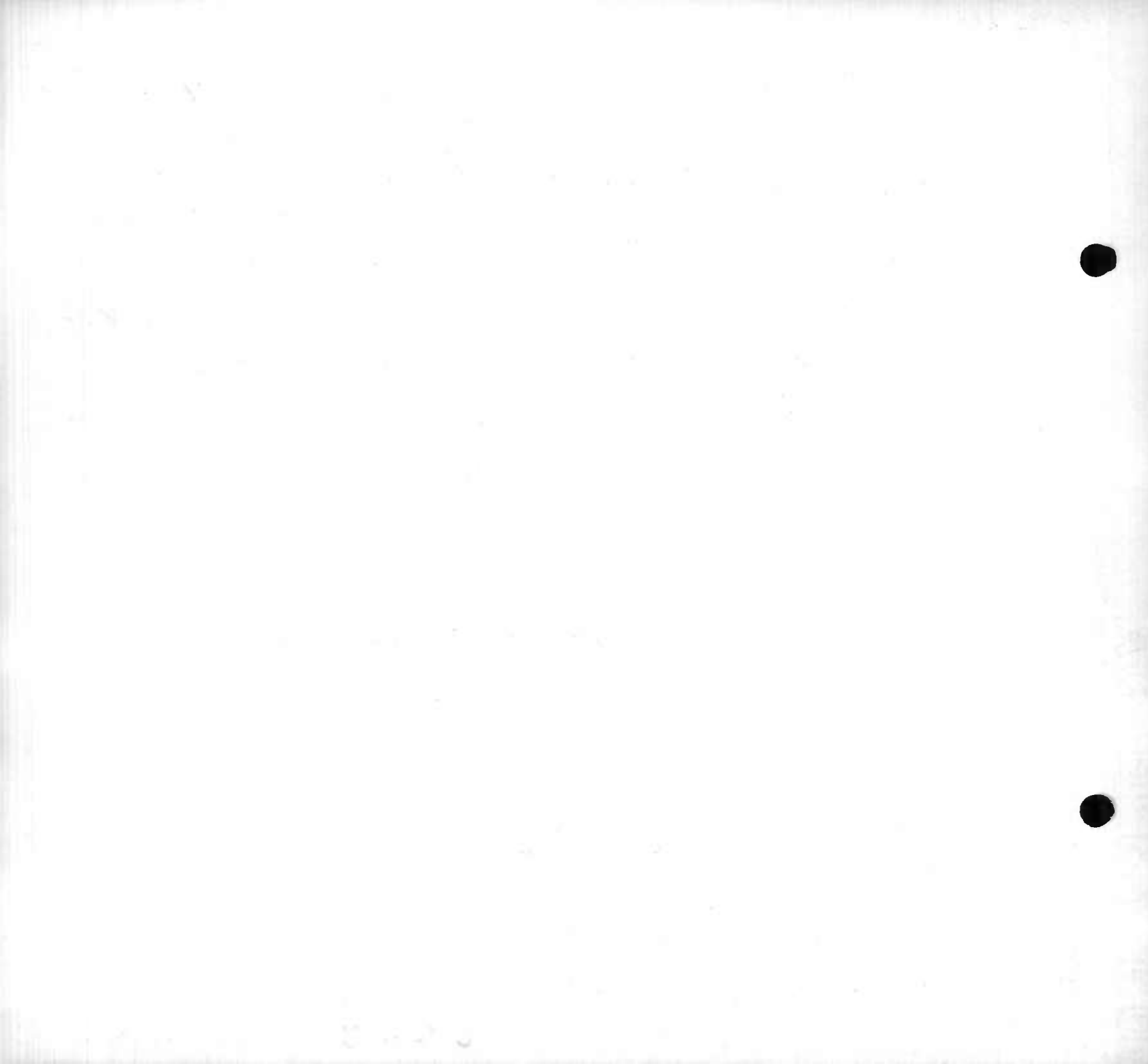
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6572 CERTIFICATE OF DEATH

REG. NO. 69 6572

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FANNIE Woodson		2. DATE AND HOUR OF DEATH 28 JUNE 1969 6 45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. STREET AND NUMBER 654 N. Gilman St 21223	
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/09	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Ayers		14. MOTHER'S MAIDEN NAME Jennie Ayers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Claude Woodson - Sane	
18. 571.01		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Loennek's Cirrhosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). hepatic Encephalopathy					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10 JUNE 1969 to 28 JUNE 1969 that (we) last saw the deceased alive on 28 JUNE 1969 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view view the body after death.					
23A. SIGNATURE Morris Ostroff, MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 28 JUNE 1969	
23C. PHYSICIAN'S NAME (Type) MORRIS OSTROFF, MD		23D. ADDRESS Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 7-269	24C. NAME of CEMETERY or CREMATORY Libertus Cent		24D. LOCATION (City, town, or county) (State) Libertus Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969	25B. NAME OF REGISTRAR James E. Talbot, R.D.		25C. FUNERAL DIRECTOR Clayton Wilson		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 69 6573	
69 6573 CERTIFICATE OF DEATH											
BIRTH NO.		M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)		MINNIE W. JONES								2. DATE AND HOUR OF DEATH June 26 1969 10 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location)		A. STATE MARYLAND								B. COUNTY 1601	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE									
D. STREET ADDRESS (If rural, give location)		1023 HARLEM AVE									
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH MAY 2, 1897		9. AGE (in years lost birthday) 72		If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife				Baltimore Md.		Baltimore Md.		U.S.A.			
13. FATHER'S NAME HOWARD W. WASHINGTON		14. MOTHER'S MAIDEN NAME MARY FRANCES MOORE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-74-1883		17. INFORMANT ZELL WASHINGTON		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH							
412.41		Arteriosclerotic Cardiovascular Disease		?							
ANTECEDENT CAUSES		(A) DUE TO		(B) DUE TO		(C) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Coronary Insufficiency		?							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTO. SY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from April 7 1969 to June 26 1969		that (I) (we) last saw the deceased alive on June 24 1969		and that in (my) (our) opinion death occurred on the date		and hour and from the causes stated above, (I) (We) (did not) view the body after death.					
23A. SIGNATURE Louis T. Lavy		M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 29 1969					
23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY		M.D.		23D. ADDRESS 3502 W. Rogers Ave Baltimore Md							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-30-69		24C. NAME of CEMETERY or CREMATORY Mt Carmel Cmt		24D. LOCATION (City, town, or county) (State) Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Kelsey Charlesworth Buntzky		ADDRESS					



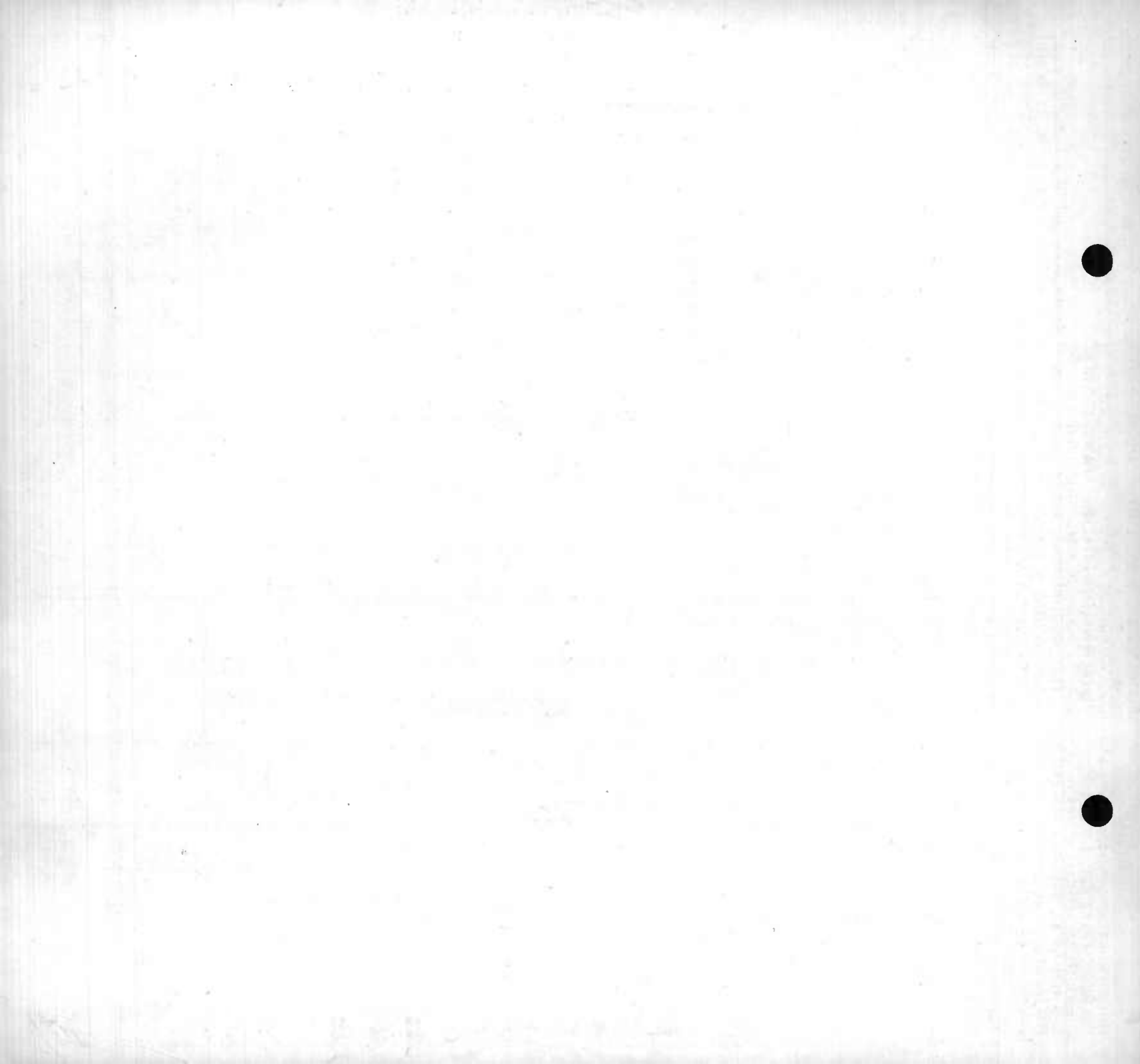
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6574 CERTIFICATE OF DEATH

REG. NO. 69 6574

BIRTH NO.		1. NAME OF DECEASED (Type or Print) VIVIAN TYSON		2. DATE AND HOUR OF DEATH June 27, 1969 5:32 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 804		C. CITY OR TOWN BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION AMELCHOR NURSING		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-14-20		9. AGE (In years, lost birthday) 49		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME THOMAS GREEN		14. MOTHER'S MAIDEN NAME ATKINSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-14-1731		17. INFORMANT EUGENE TYSON ADDRESS 2315 HOFFMAN ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinoma of Rectum		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Was or No? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 3 19 69 to June 27 19 69 , that (I) (we) last saw the deceased alive on June 26 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman M.D.		23B. DATE SIGNED 6/27/69		23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.	
23D. ADDRESS 3202 Hartford Rd., Baltimore, Md.		24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-1-69	
24C. NAME OF CEMETERY or CREMATORY Pratto Natl Cent		24D. LOCATION (City, town, or county) Baltimore		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Miller, M.D.		25C. FUNERAL DIRECTOR E. E. Miller ADDRESS 2101	



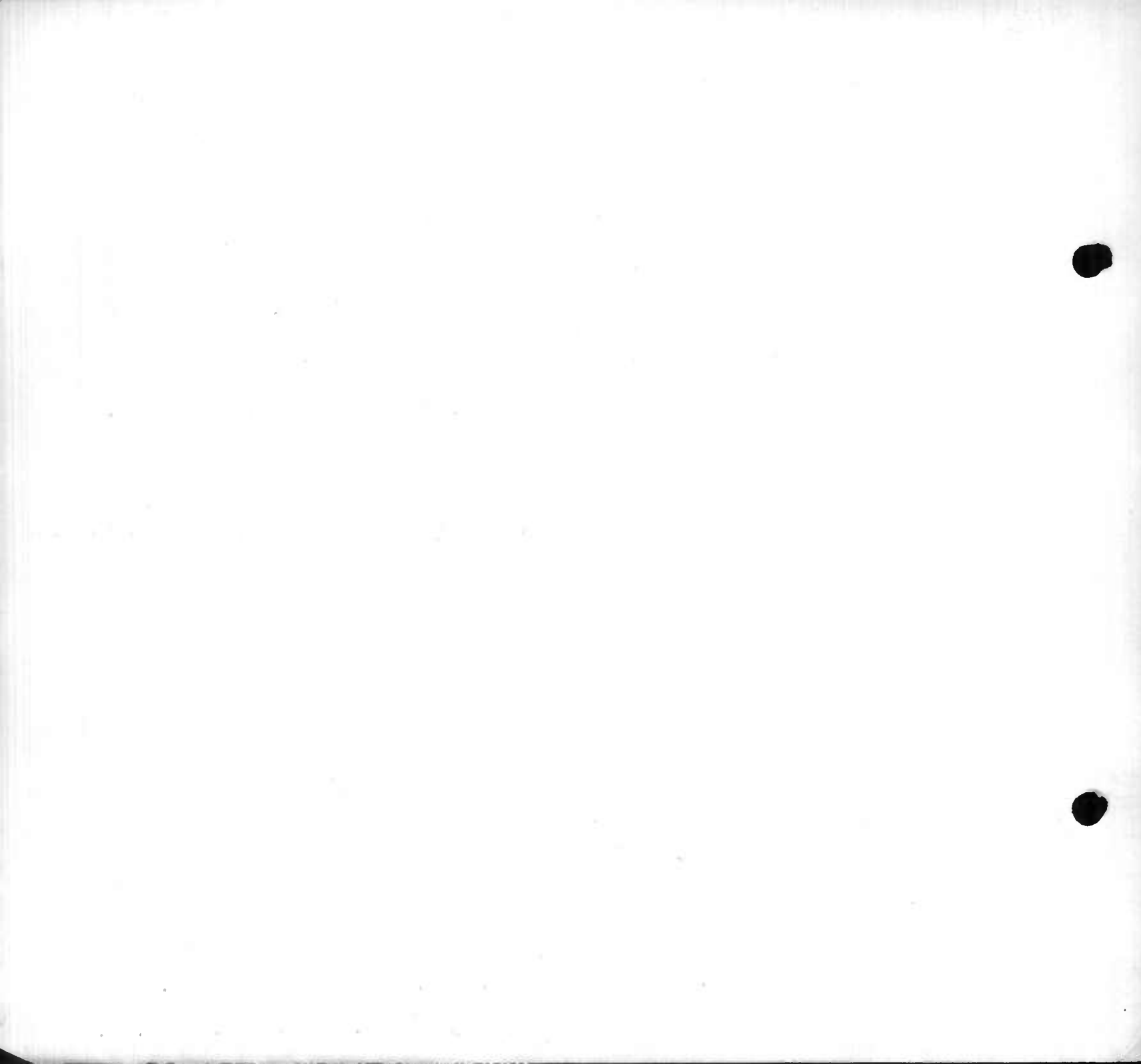
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6575 CERTIFICATE OF DEATH

REG. NO. 69 6575

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY GRACE SANFORD		2. DATE AND HOUR OF DEATH 6/25/69 6⁵⁵ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 906		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/13/96 98	9. AGE (In years last birthday) 70 42	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NO CHART Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Holden		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-1853D		17. INFORMANT Mr. J oseph Harlan, Title Bldg. #02	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that W (this hospital) attended the deceased from 6/25 19 69 to 6/25 19 69 that (I) W last saw the deceased alive on 6/25 19 69 and that in (my) W opinion death occurred on the date and hour and from the causes stated above. (I) W (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 6/25/69		23C. PHYSICIAN'S NAME (Type) LUIS CINTADO MD	
23D. ADDRESS UNION MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69	
24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Cem.		24D. LOCATION (City, town, or county) (State) Elkridge, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969	
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonardo J. Ruck, Inc. Balto. Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 6576 **CERTIFICATE OF DEATH**

REG. NO. 69 6576

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William L. Johnson, Sr.</i>		2. DATE AND HOUR OF DEATH <i>June 29, 1969. 2:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>906</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>45 Good Samaritan Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1603 Chilton Ave.</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 7, 1895.</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Brewery</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Louis W. Johnson</i>			14. MOTHER'S MAIDEN NAME <i>Emma V. Smith</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-01-1971</i>	17. INFORMANT <i>Mrs. Ruth C. Johnson</i>		ADDRESS <i>(Same)</i>
18. <i>257091</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Brain stem CVA</i> <i>Chronic Renal Failure +</i> <i>Atherosclerotic Cardiovascular disease 14 years</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes Mellitus</i> <i>20+ years</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hours.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>History of myocardial infarction x 2</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 9</i> 19 <i>69</i> to <i>June 29</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>June 29</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David H. Huffman M.D.</i>			23B. DATE SIGNED <i>June 29, 1969.</i>		23C. PHYSICIAN'S NAME (Type) <i>David H. Huffman</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>7/2/69.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1969</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			25C. FUNERAL DIRECTOR <i>Leonard J. Guck, Inc. Balto. Md. 21214</i>		

History of hospital infections
Shedden, H. H.
University of California Press
Berkeley, California
1965

Shedden, H. H.

June 20, 1965

June 20, 1965

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 6577		69 6577		69 6577	
1. NAME OF DECEASED (Type or Print) <u>Ignatius J. Ayd</u>		2. DATE AND HOUR OF DEATH <u>6/28/69</u> <u>6:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>44 UNION MEMORIAL Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2633</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/2/91</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rutines Police</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Police Dept.</u>		9. AGE (In years lost birthday) <u>78</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Ayd</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Schmidt Kircher</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>212-28-9917</u>	
17. INFORMANT <u>Mrs. Mabel Ayd daughter</u>		ADDRESS (Same)		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIO-PULMONARY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Subacute pulmonary EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Co of Prostate (inoperable)</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>69</u> to <u>6/28</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>6/28/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Carlton E. Foss</u>	
23D. ADDRESS <u>44 UNION MEMORIAL Hospital</u>		23E. NAME OF REGISTRAR <u>Robert E. Foss, M.D.</u>		23F. FUNERAL DIRECTOR <u>Leonard J. Rick, Inc.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/2/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		24F. NAME OF REGISTRAR <u>Robert E. Foss, M.D.</u>	
24G. FUNERAL DIRECTOR <u>Leonard J. Rick, Inc.</u>		24H. ADDRESS <u>Balto. Md. 21211</u>		24I. DATE <u>6-5-69</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6578			
1. NAME OF DECEASED (Type or Print) Guiseppe Longo				2. DATE AND HOUR OF DEATH 6/29/69 2:15 PM							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY Balt city C. CITY OR TOWN Baltimore city D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3013 Watfield Ave							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-33	9. AGE (In years last birthday) 36	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason				10B. KIND OF BUSINESS OR INDUSTRY Ret.				11. BIRTHPLACE (State or foreign country) Italy.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Salvatore Longo				14. MOTHER'S MAIDEN NAME Sarah Lobastolo			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 218 0 2103		17. INFORMANT Mary Longo wife		ADDRESS same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/24/69 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH cerebral vascular accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AS CV D years renal failure				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS CV D years (B) DUE TO, OR AS A CONSEQUENCE OF: renal failure (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 0 Now				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/25/69 to 6/29/69 , that (I) (we) last saw the deceased alive on 6/29/69 and that in (my) (our) opinion death occurred on the date and hour specified from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Brian Block								23B. DATE SIGNED 6/29/69		23C. PHYSICIAN'S NAME (Type) BRIAN BLOCK	
23D. ADDRESS UNION MEMORIAL HOSPITAL								23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/2/69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969				25B. NAME OF REGISTRAR Robert E. Taylor, Jr.				25C. FUNERAL DIRECTOR Leonard J. Duck Inc.			
								ADDRESS Balto. Md.			

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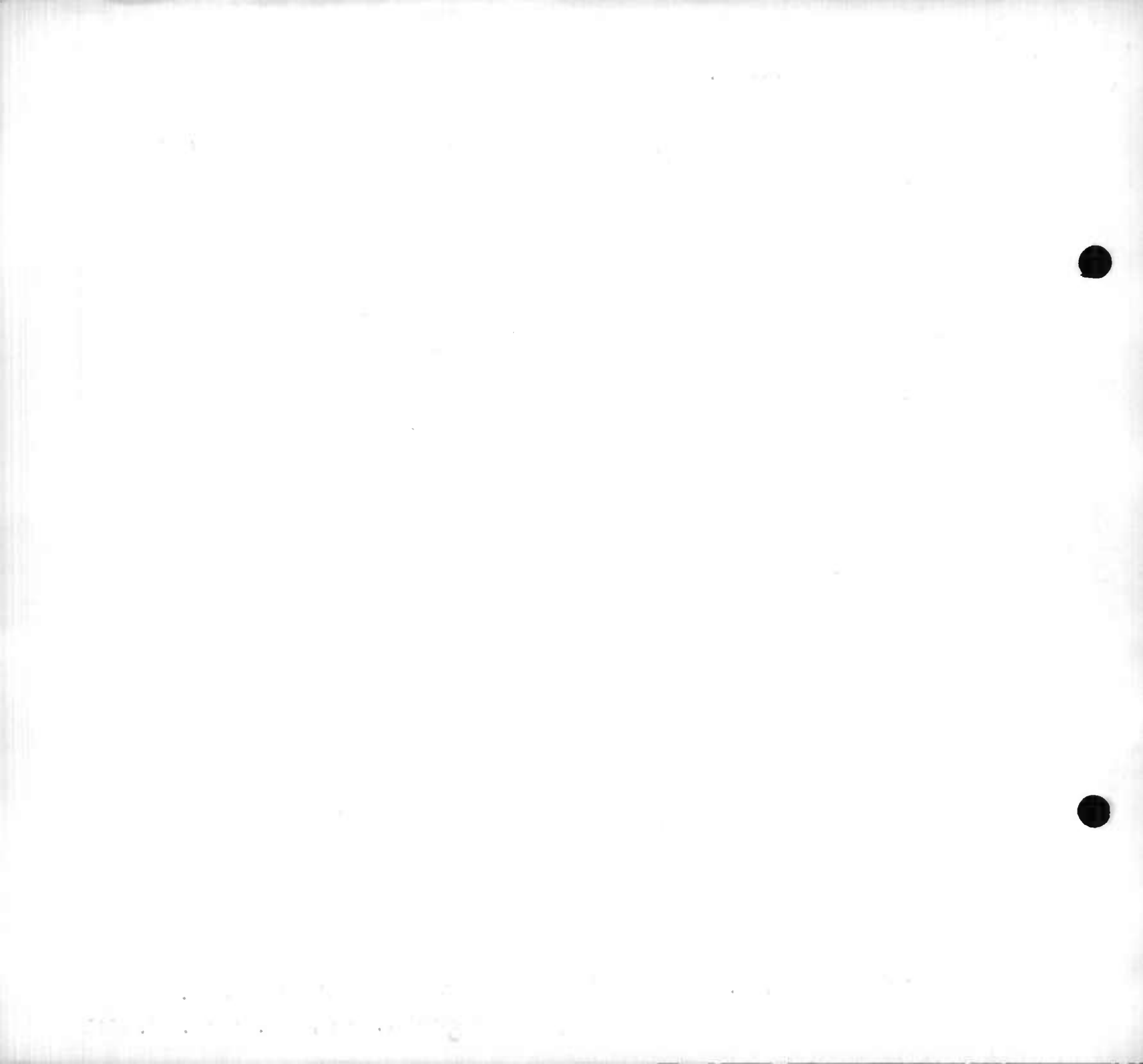
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6579</u>	
BIRTH NO. <u>69 6579</u>					
1. NAME OF DECEASED (Type or Print) <u>FRANK J. ROSEMER</u>			2. DATE AND HOUR OF DEATH <u>6-29-69</u> <u>5:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 CHURCH HOME & HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2643</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3819 LYNDALE AVE.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-99</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TOOL & DYE MAKER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN ROSEMER</u>			14. MOTHER'S MAIDEN NAME <u>Catherine KIRSCHER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 09 7885</u>		17. INFORMANT <u>ELLEN ROSEMER</u>	
				ADDRESS <u>SAME</u>	
18. <u>41011</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarct</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>cardiac arrest</u> <u>Acute Pulmonary edema</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 29 1969</u> to <u>June 29 1969</u> that (I) (we) last saw the deceased alive on <u>June 29 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Corazon Z. Vergara, M.D.</u>			23B. DATE SIGNED <u>June 29, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>
			23D. ADDRESS <u>100 N. BROADWAY, BALTIMORE, Md. 31</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/3/69.</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>Leonard J. Ruck, Inc.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

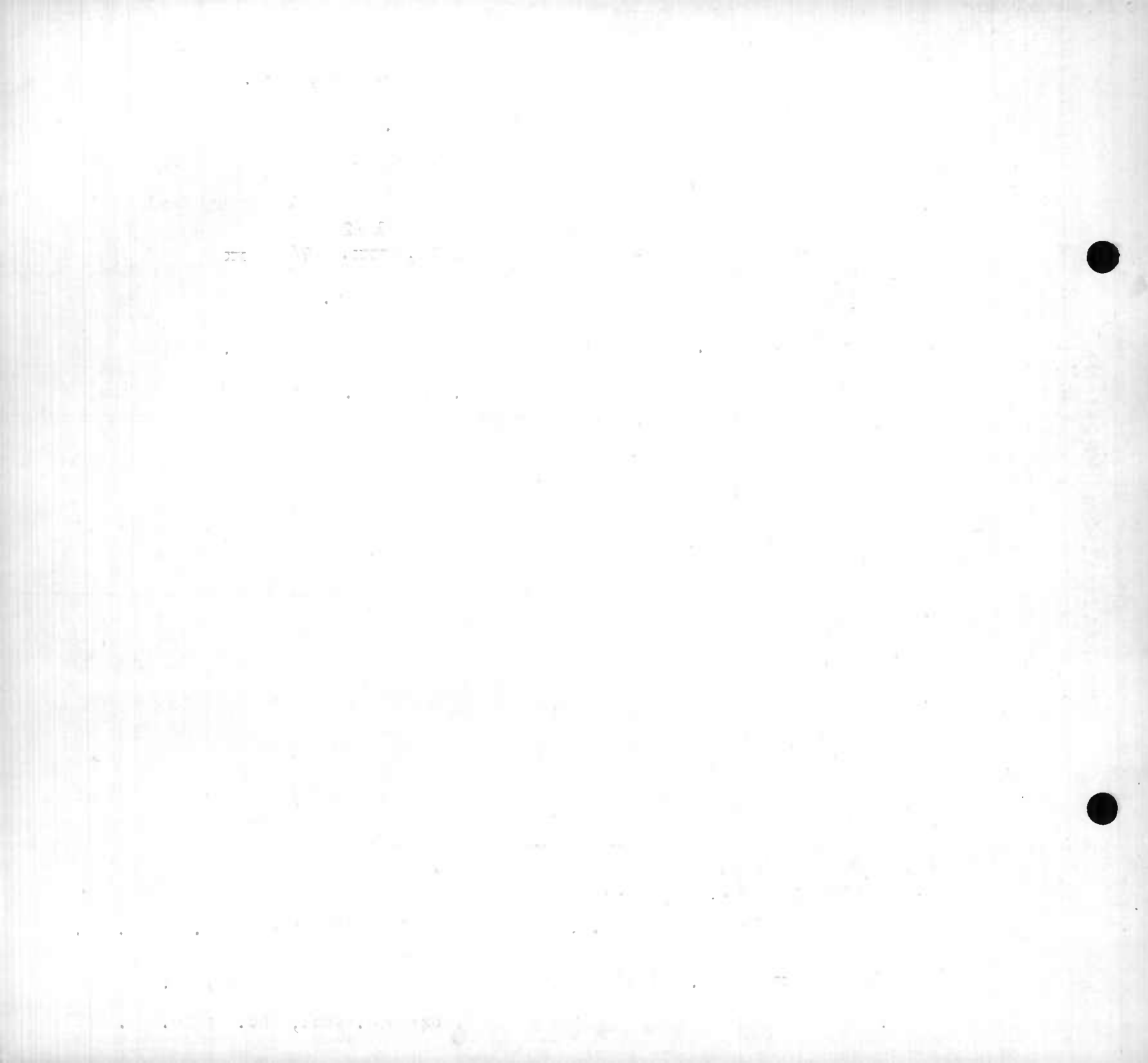
BIRTH NO.

1. NAME OF DECEASED (Type or Print) TERRANCE (TERRY) E. SMITH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 28, 1969 9:50 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1969 9:50 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 604		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-10-1951	10. AGE (In years lost birthday) 17	E. STREET AND NUMBER 12 N. Ann Street	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIKE CONST. CO.		13. FATHER'S NAME CLEVE W. SMITH	
14B. KIND OF BUSINESS OR INDUSTRY PIKE CONST. CO.		15. MOTHER'S MAIDEN NAME EDITH I. STOUT	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 243-58-1995	
18. INFORMANT CLEVE W. SMITH		ADDRESS 17 N. BROADWAY	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 88 B X		CAUSE OF DEATH Fracture dislocation with cervical spine and spinal cord injury	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Franklinville Bridge-Upper Falls, Balt. County		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 6/23/69 8:35 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Dove off rock into shallow water	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) (Partial) Yes	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-2-69	
24C. NAME OF CEMETERY or CREMATORY LINGANORE CEMETERY		24D. LOCATION (City, town, or county) (State) UNIONVILLE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC.		ADDRESS 4015 CHESTER ST.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

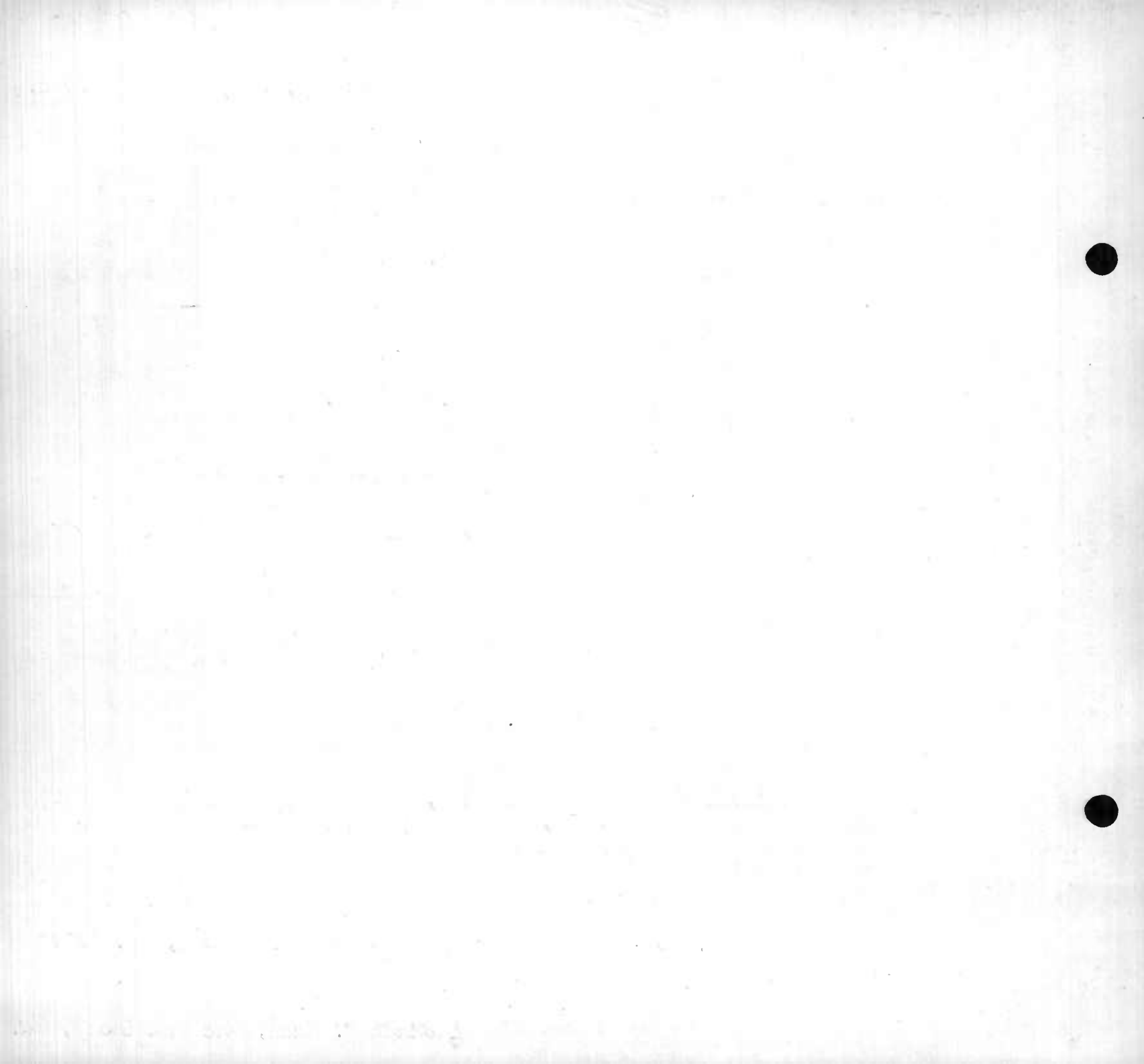
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6581</u>
BIRTH NO. <u>69 6581</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>MARIAN STAINES</u>		2. DATE AND HOUR OF DEATH <u>June 27, 1969.</u> <u>12:30</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 1318 Asbury Road</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2755</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1318 Asbury Road</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u> <u>July 27, 1892</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Ernest W. Allen</u>		14. MOTHER'S MAIDEN NAME <u>Etta S. Hurlbut</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mr. Joseph E. Hess</u>	
				ADDRESS (Same)
18. <u>153.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Sigmoid</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 52</u> to <u>June 27, 1969</u> , that (I) (we) last saw the deceased alive on <u>6/27/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Julius C. Gluck, M.D.</u>			23B. DATE SIGNED <u>6/28/69.</u>	
23C. PHYSICIAN'S NAME (Type) <u>Julius Gluck M.D.</u>			23D. ADDRESS <u>5356 Reisterstown Rd. Balto. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/1/69.</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>	25B. NAME OF REGISTRAR <u>Wm. E. Taber, M.D.</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Buck, Inc. Balto. Md. 21214</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6582	
BIRTH NO. 69 6582		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Anna Annie May Smith		2. DATE AND HOUR OF DEATH June 27, 1969 10 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 132 Hopkins Road			
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1886	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Slee		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Billy L. Smith (Same)	
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 3, 1969 to June 27, 1969 , that (I) (we) last saw the deceased alive on June 27, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do not) view the body after death.					
23A. SIGNATURE Laurence C. Post M.D.				23B. DATE SIGNED 6/27/69	
23C. PHYSICIAN'S NAME (Type) Laurence C. Post		23D. ADDRESS 6805 York Road Baltimore, Md. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Edward J. Ruck, Inc Baltimore, Md.	

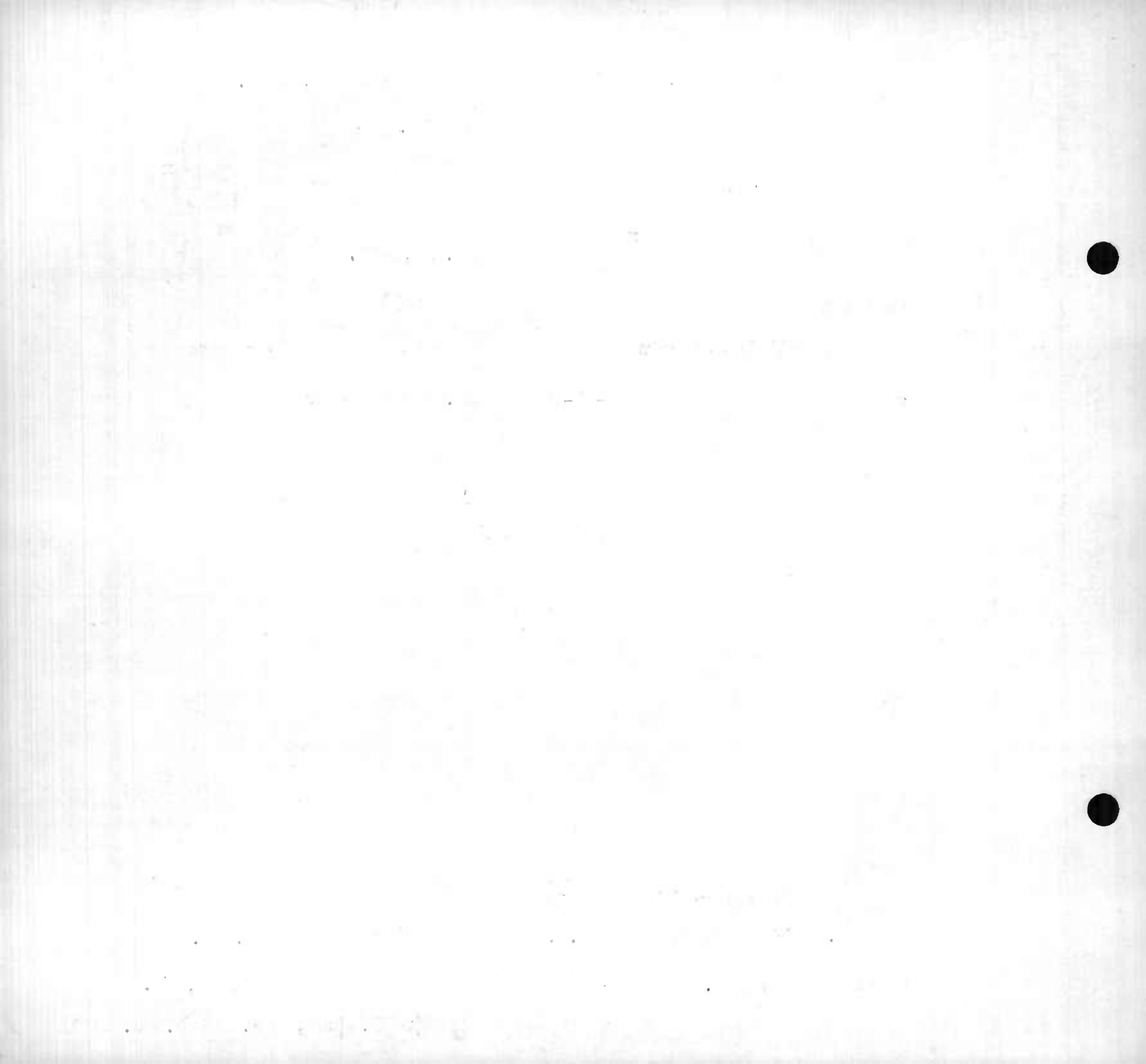


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6583 BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH REG. NO. 69 6583

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM F. DOEHRING		June 28, 1969. 11 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3400 Echodale Avenue			A. STATE Md. B. COUNTY 2744		
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1911.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 58
Machinist			Maryland		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Doehring			Clara Moser		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			214-01-5268		Mrs. Evelyn Doehring (Same)
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary occlusion		
ANTECEDENT CAUSES			(B) Under chronic heart disease 5 yrs		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) ...		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1969 to June 1969, that (I) (we) last saw the deceased alive on June 29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
S. Elliott Harris M.D.				6/28/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
S. Elliott Harris		8100 Harford Road Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/1/69.		Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 1 1969		George E. Taber, M.D.		Leonard J. Duck, Inc. Balto. Md. 21214	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DOROTHY THRON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 26, 1969

11:03 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2844

6. SEX

Female

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

8/27/1893

10. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

E. STREET AND NUMBER

1109 Walnut Avenue

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Jackson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Florence

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

216-03-6785

18. INFORMANT

ADDRESS

Mr. Henry F. Thron, 1109 Walnut Ave., 21229

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Alcohol and Barbiturate Ingestion

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) complicated by Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1109 Walnut Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

June 1969

Unk.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject ingested alcohol and barbiturate

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/30/69

24C. NAME OF CEMETERY or CREMATORY

Western Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1969

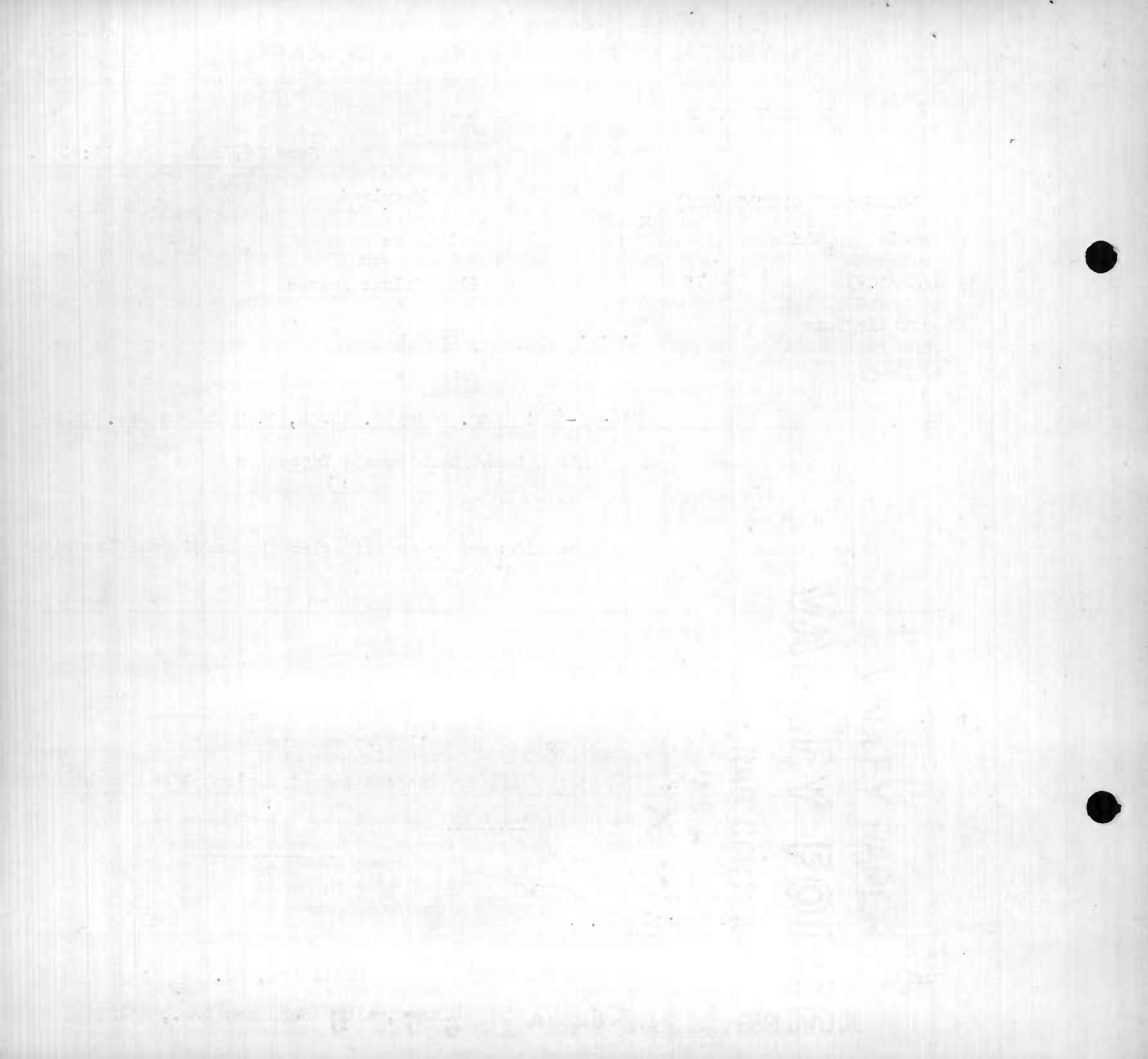
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Witzke, 4101 Edmondson Ave., 21229

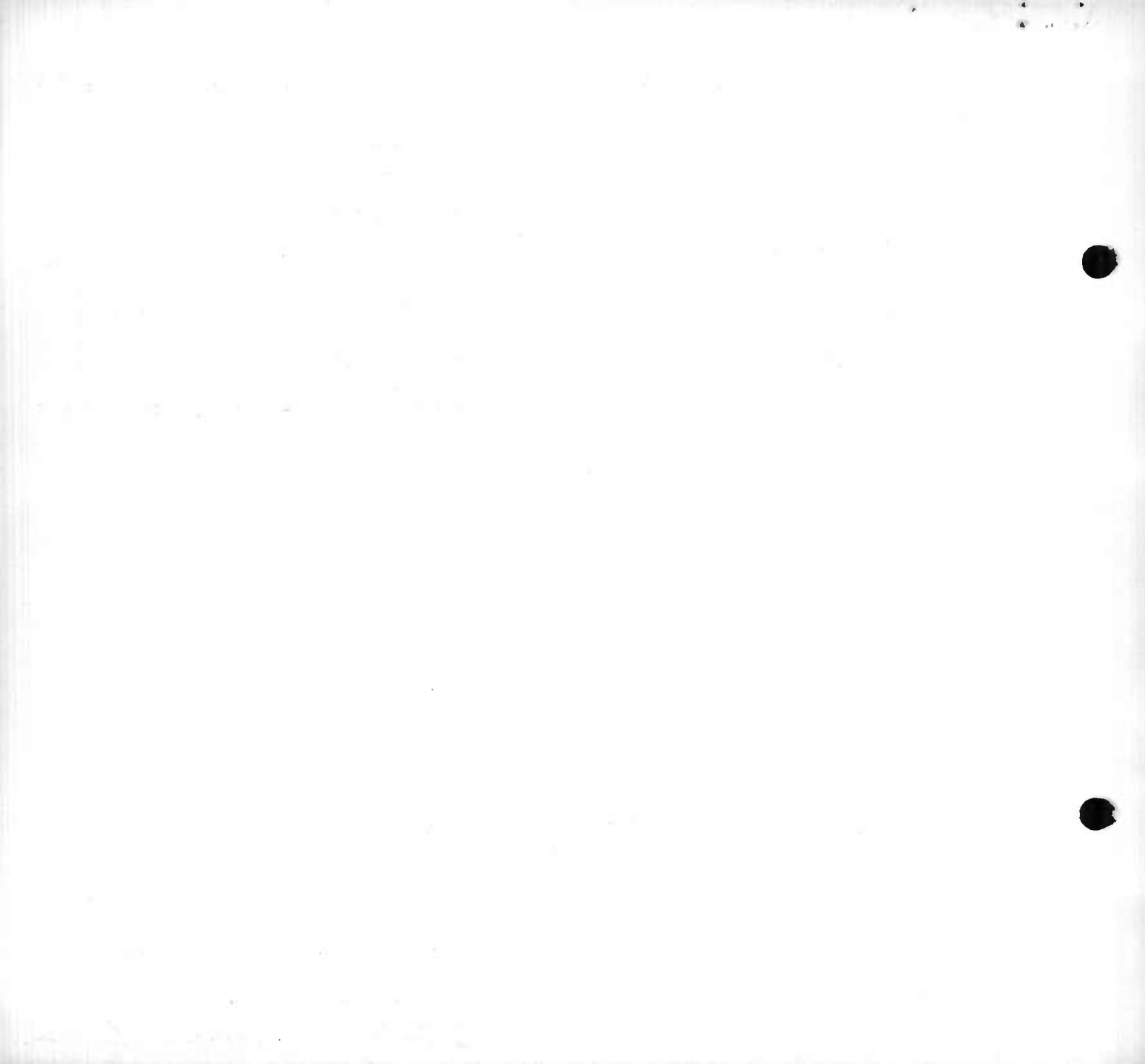
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

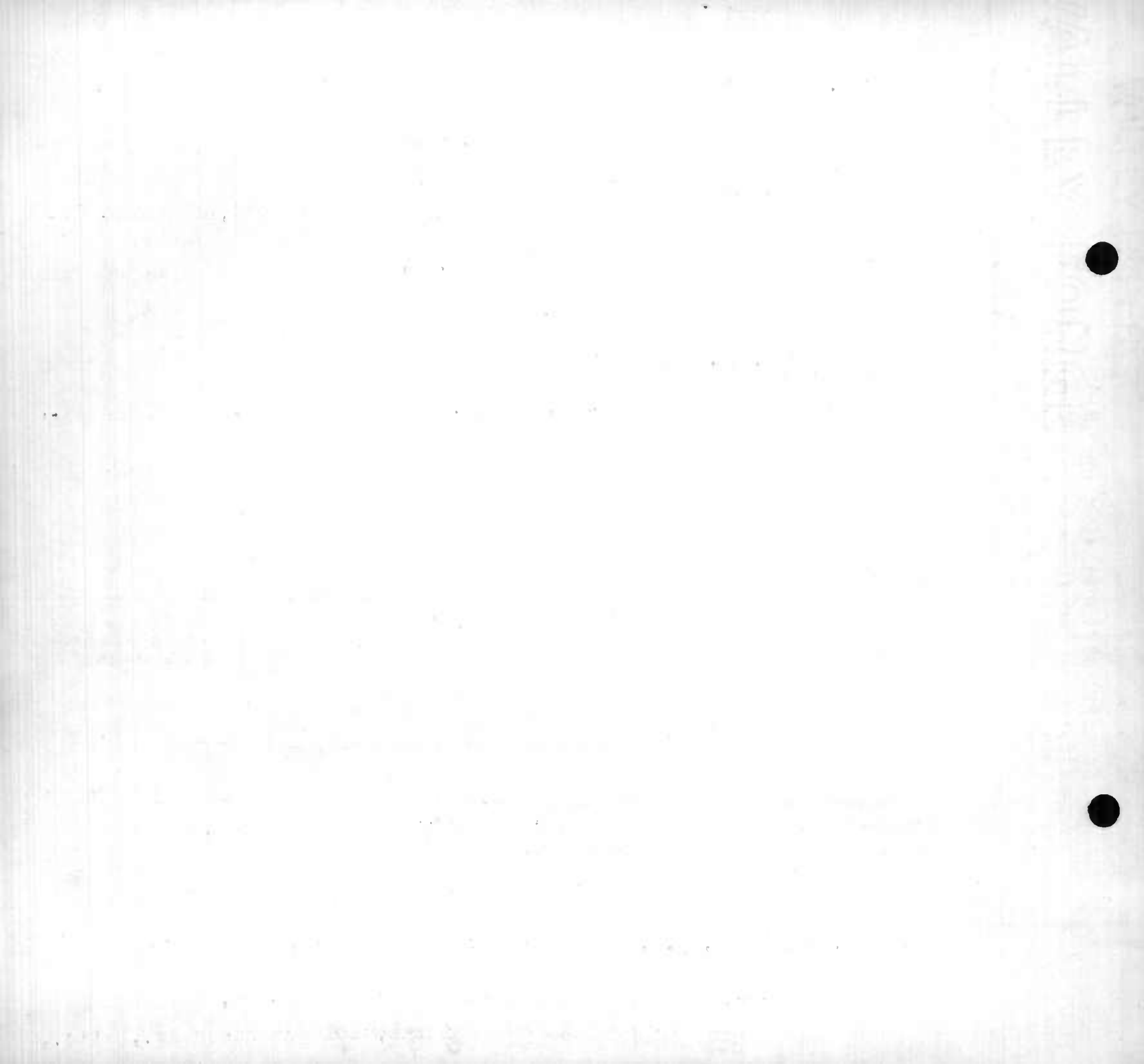
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 69 6585	
BIRTH NO. 69-12606 69 6585				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) YATES, BABY				2. DATE AND HOUR OF DEATH JUNE 25, 1969 4:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY HOCO. 5200 C. CITY OR TOWN ODENTON D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 490 PATUXENT RD			
5. SEX ?	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06 25 69	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME ROBERT YATES				
14. MOTHER'S MAIDEN NAME SHARON WATKINS			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS ST AGNES RECORDS-CATON & WILKENS AVE				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Multiple Congenital DUE TO, OR AS A CONSEQUENCE OF: (B) Abnormalities DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 25 1969 to JUNE 25 1969 that (X) (we) last saw the deceased alive on JUNE 25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE S. Aziz, M.D.				23B. DATE SIGNED 6-26-69		23C. PHYSICIAN'S NAME (Type) S. Aziz, M.D.	
23D. ADDRESS ST AGNES HOSP. BALTO MD 21229				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR E. Talley, M.D.		25C. FUNERAL DIRECTOR H. E. Finkbeiner		25D. ADDRESS Home 4101 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

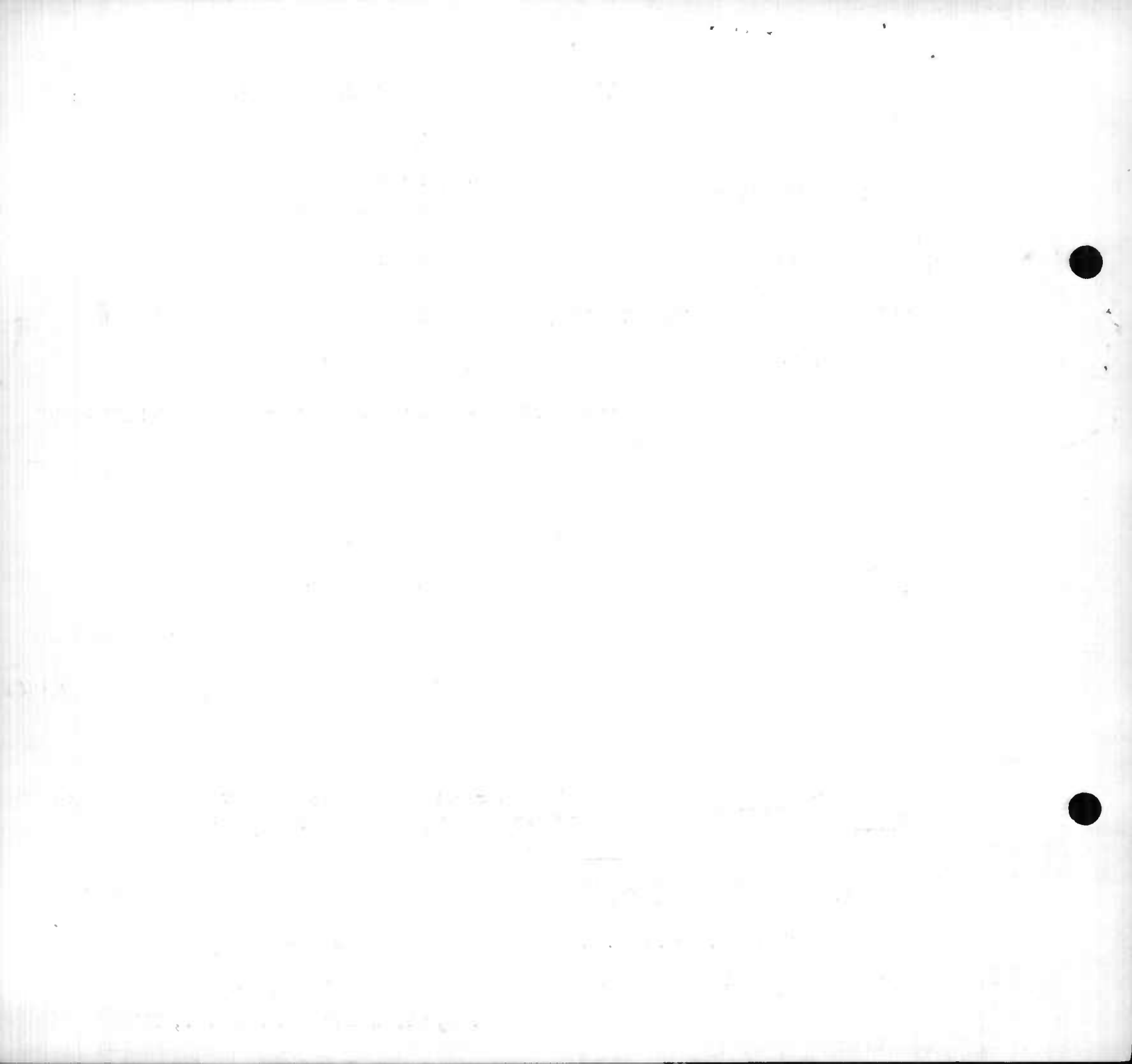
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6586	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lucy L. DiSante		2. DATE AND HOUR OF DEATH June 28 1969 1930 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2864		
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Apr. 24, 1905		9. AGE (In years lost birthday) 64		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier			10B. KIND OF BUSINESS OR INDUSTRY Hutzler Bros.		11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME (late) Domonick D. Giralamo		
14. MOTHER'S MAIDEN NAME (late) Michaelina			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 215-42-9665			17. INFORMANT Mr. Reginald DiSante, 1325 Ridge Rd., 28		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A.C.V.H.D ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (B) (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ① Hypertension. ② Disc syndrome L4-L5.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 5 1964 to June 28 1969 , that (I) (we) last saw the deceased alive on June 4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Schaefer MD				23B. DATE SIGNED June 30 1969	
23C. PHYSICIAN'S NAME (Type) John F. Schaefer, M.D.				23D. ADDRESS 401 Random Road, Baltimore, Md 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Witke, 4101 Edmondson Av., Balto., Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 69 6587	
BIRTH NO. (9)				69 6587		X	
1. NAME OF DECEASED (Type or Print) SCHAFFER, CLYDE WILLIAM				2. DATE AND HOUR OF DEATH JUNE 27, 1969 5:00 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD OST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO CO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 135 NEWBURG AVE			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 17 86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY MEAT BUSINESS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME GEORGE SCHAFFER				14. MOTHER'S MAIDEN NAME MARTHA SHAULL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO. 213051075		17. INFORMANT ST AGNES RECORDS-CATON & WILKENS AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPTICEMIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs -			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, leading up to the above cause (1A) stating the UNDERLYING CONDITION last. AGAMULOCYTOSIS Following PROMESTYL Administration				20. DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular disease & non-functional			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XIX (this hospital) attended the deceased from JUNE 26 1969 to JUNE 27 1969 and that XI (we) last saw the deceased alive on JUNE 27 1969 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James G. Kane, Jr., M.D.				23B. DATE SIGNED 06 27 69		23C. PHYSICIAN'S NAME (Type) JAMES G KANE, JR., M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/30/69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969				25B. NAME OF REGISTRAR Walter E. Talbot, M.D.		25C. FUNERAL DIRECTOR W. W. Wozke, 4101 Edmondson Ave., 21229	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				25D. ADDRESS ST AGNES HOSP. BALTO MD 21229			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6588

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAY C. BARRINGER		2. DATE AND HOUR OF DEATH JUNE 28, 1969 9:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE B. COUNTY BALTO. CO.			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		C. CITY OR TOWN MARYLAND		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ADDRESS OR LOCATION CATON & WILKENS AVENUES		E. STREET AND NUMBER 1665 KIRKWOOD ROAD			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLADY		10B. KIND OF BUSINESS OR INDUSTRY Gaxton Co		8. DATE OF BIRTH 09-28-97	
13. FATHER'S NAME DAVIS BARRINGER		14. MOTHER'S MAIDEN NAME AGNES (DONOVAN)		9. AGE (In years last birthday) 71	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 212228664		11. BIRTHPLACE (State or foreign country) MARYLAND	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
				17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON BALTO	
				ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer Breast x 3		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. None		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction			
		(B) DUE TO, OR AS A CONSEQUENCE OF: None			
		(C) None			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 28 19 69 to JUNE 28 19 69 that (X) (we) last saw the deceased alive on JUNE 28 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE James G. Kane, M.D.				23B. DATE SIGNED 6/28/69	
23C. PHYSICIAN'S NAME (Type) JAMES G. KANE, M.D.				23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1, 1969		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Jones, M.D.		25C. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke	
				ADDRESS Baltimore City	

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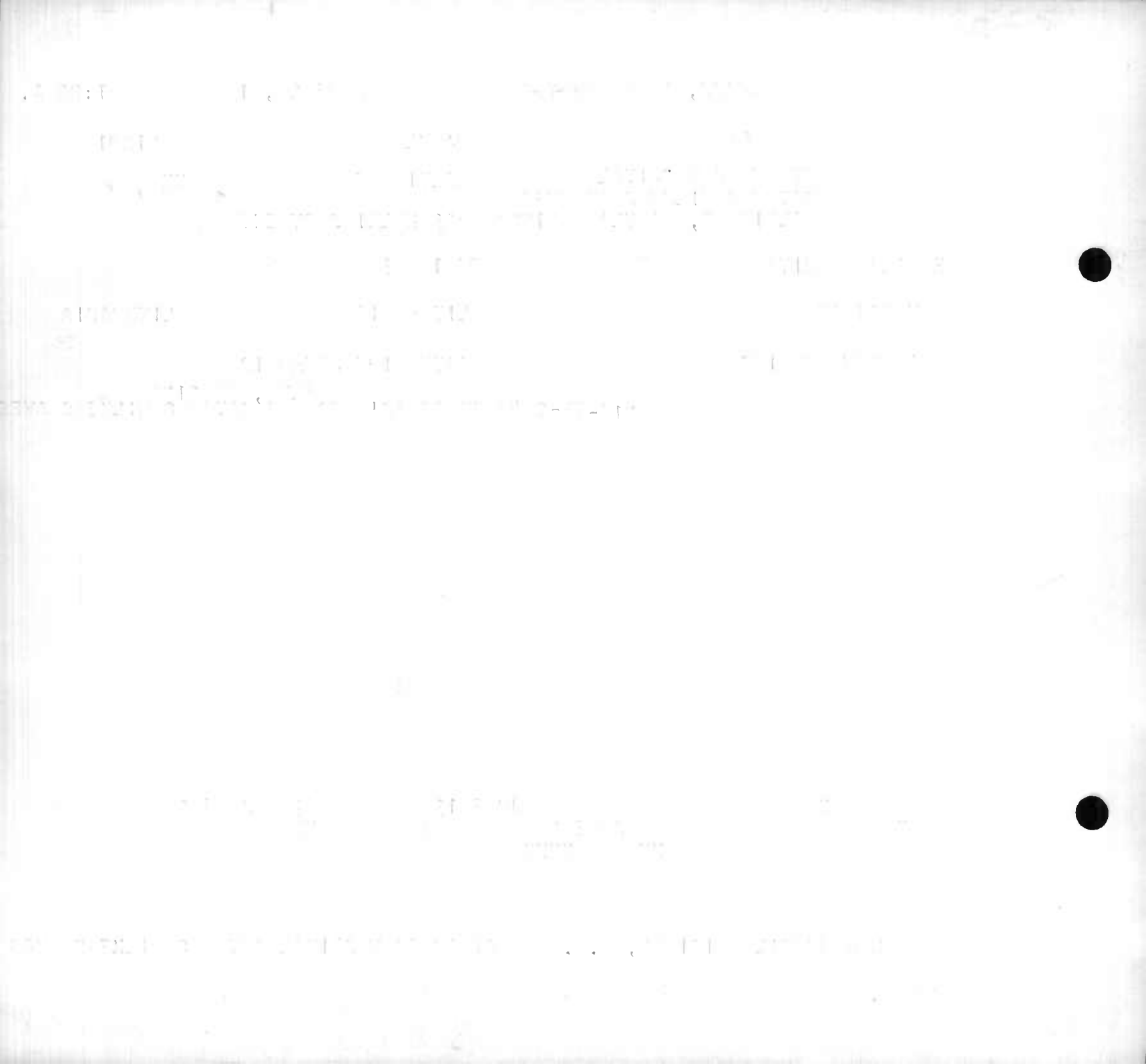
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

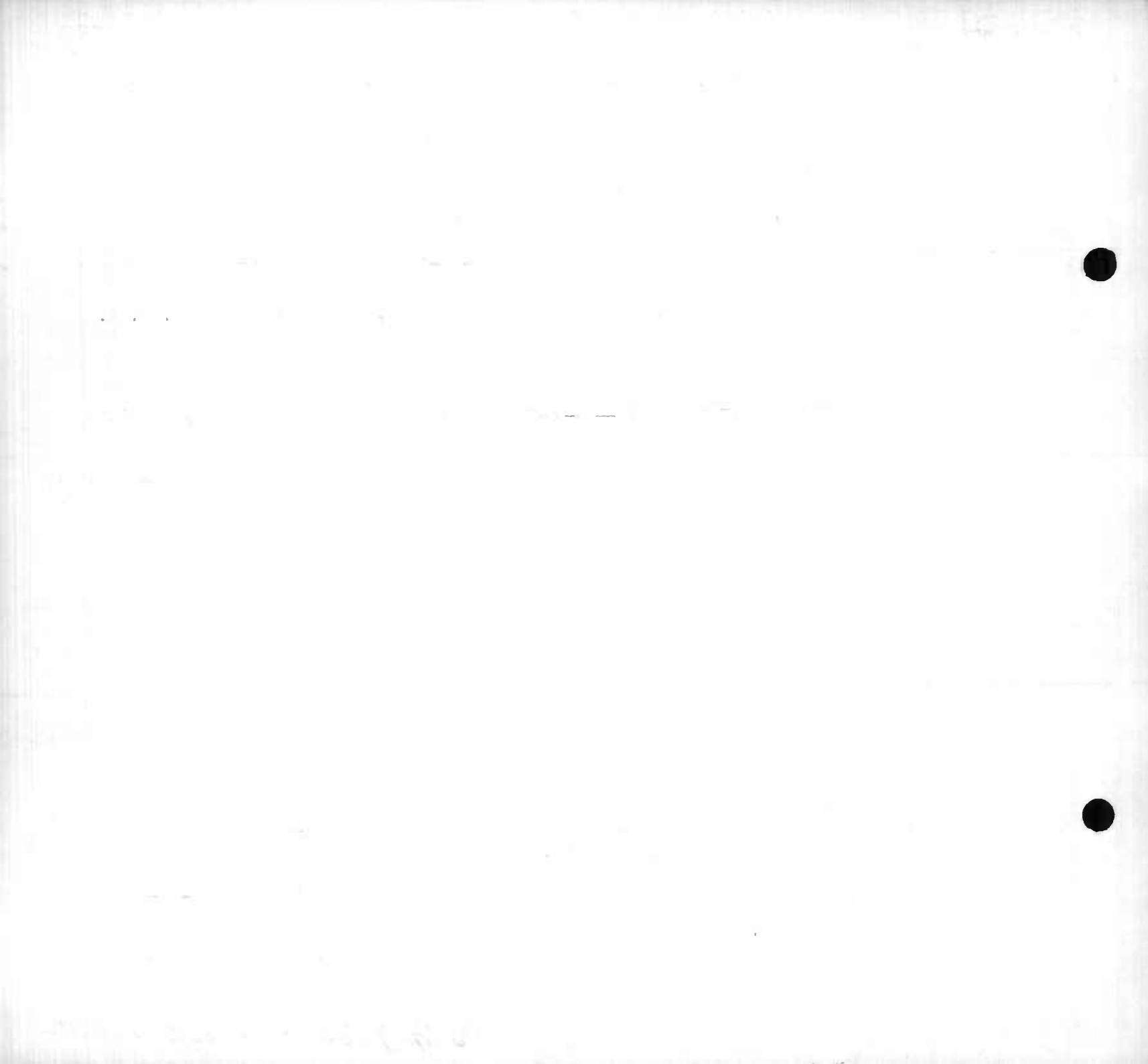
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6589	
CERTIFICATE OF DEATH			
BIRTH NO.		2. DATE AND HOUR OF DEATH JUNE 29, 1969 1:00 A.M.	
1. NAME OF DECEASED (Type or Print) REKUS, ANNA DEBORAH		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21201	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05/18/83 9. AGE (in years last birthday) 86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) LITHUANIA	
10B. KIND OF BUSINESS OR INDUSTRY Clothing		12. CITIZEN OF WHAT COUNTRY? LITHUANIA	
13. FATHER'S NAME ANDREW DOBBINS		14. MOTHER'S MAIDEN NAME CATHERINE PAKROPIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-2845	
		17. INFORMANT BALTO, MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 13 19 69 to JUNE 29 19 69 that (X) (we) last saw the deceased alive on JUNE 29 19 69 and that (X) (our) opinion of death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.			
23A. SIGNATURE Hermenegildo Isidro		23B. DATE SIGNED JUNE 29, 1969	
23C. PHYSICIAN'S NAME (Type) HERMENEGILDO ISIDRO, M.D.		23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-1969	
24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Viggo E. Gibson, M.D.	
25C. FUNERAL DIRECTOR Thomas J. Korry		ADDRESS Baltimore Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6590				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6590			
1. NAME OF DECEASED (Type or Print) KUCHAUSKAS, Peter Edward				2. DATE AND HOUR OF DEATH 28 JUNE 1969 7:55 A M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				A. STATE & COUNTY MARYLAND BALTIMORE CITY 2101							
				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 645 WASHINGTON BOULEVARD							
5. SEX MALE		6. RACE CAUCASION		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5-29-14		9. AGE (in years last birthday) 55		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10B. KIND OF BUSINESS OR INDUSTRY WHOLESALE BUSINESS				11. BIRTHPLACE (State or foreign country) WATERBURY, CONNECTICUT			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME CHARLES KUCHAUSKAS				14. MOTHER'S MAIDEN NAME ELIZABETH RUTKAUS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 3-15-48 TO 1-7-52				16. SOCIAL SECURITY NO. 215-10-0727				17. INFORMANT V A HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTO, MD 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchogenic Carcinoma E extensive metastasis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL MONTHS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, lam, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from 26 MAY 19 69 to 28 JUNE 19 69 that (X) (we) last saw the deceased alive on 28 JUNE 19 69 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.											
23A. SIGNATURE SALAH M. NASRALLAH M.D.				23B. DATE SIGNED 6-28-69							
23C. PHYSICIAN'S NAME (Type) SALAH M. NASRALLAH				23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-2-1969		24C. NAME of CEMETERY or CREMATORY Barto National Cem		24D. LOCATION (City, town, or county) (State) Barto Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR J. J. J. J. J.		25C. FUNERAL DIRECTOR Thompson & Kennedy Inc		ADDRESS Barto Md					



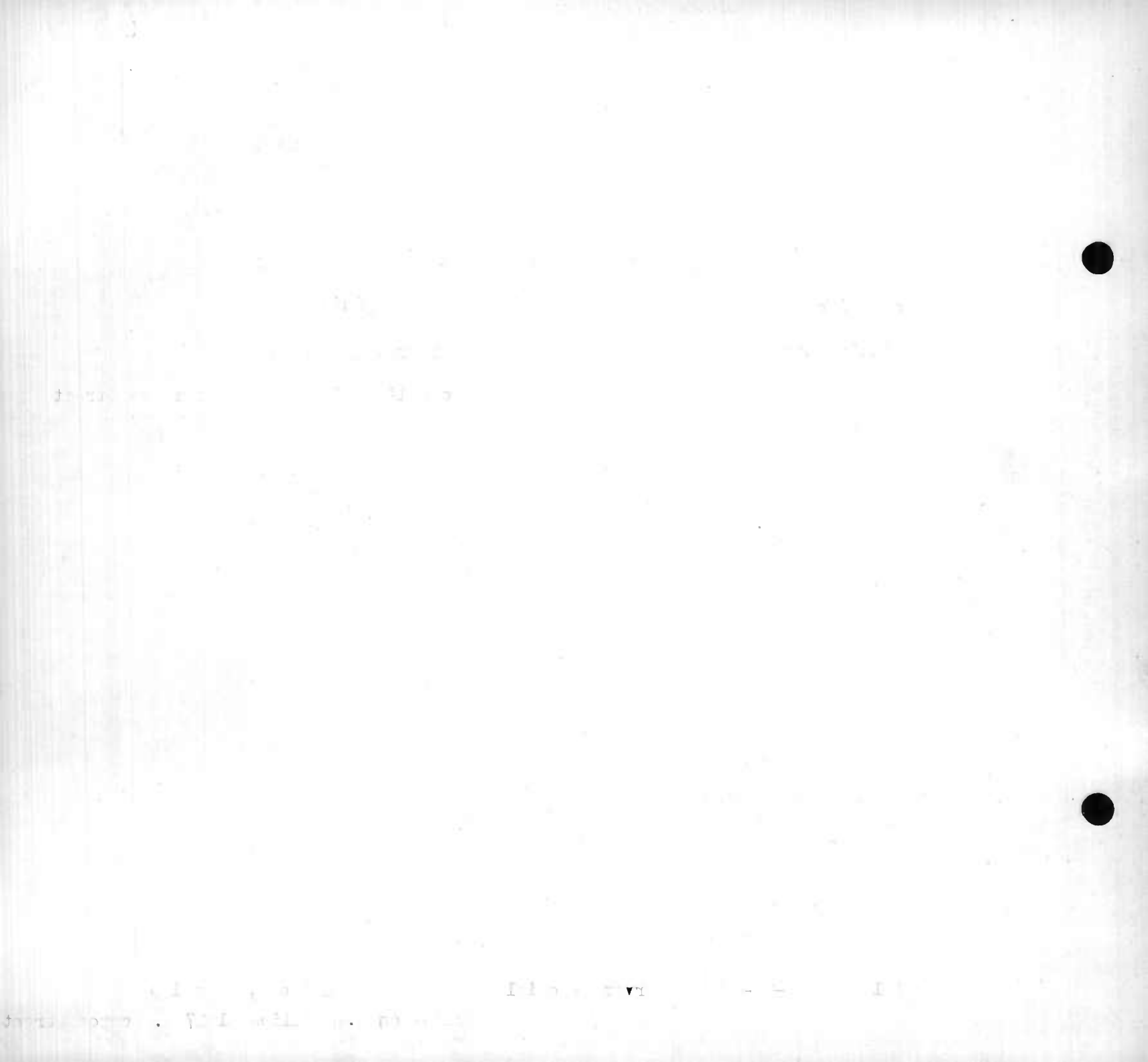
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6591 CERTIFICATE OF DEATH

REG. NO. **69 6591**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Greenway, Ida L.		2. DATE AND HOUR OF DEATH 6/26/69 6:00 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE md. B. COUNTY 7		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hosp. of Md.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1888		9. AGE (In years last birthday) 81		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William Lee		14. MOTHER'S MAIDEN NAME Margaret (Unknown)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Cornelia Phipps 2709 Presbury Street	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple embolization of Lt. Lung.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHCVD & CHF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/26 19 69 to 6/26 19 69 . that (I) (we) last saw the deceased alive on 6/26 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hyung K. Park M.D.		23B. DATE SIGNED 6/26/69		23C. PHYSICIAN'S NAME (Type) Hyung K. Park M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-69		24C. NAME OF CEMETERY or CREMATORY Carver Memorial	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Phillips, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727 N. Monroe Street		25E. ADDRESS 1727 N. Monroe Street	



69 6592

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6592

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES HAMMOCK

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
June 29, 1969 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

(DOA)

South Baltimore General Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
June 29, 1969 2:50 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2301

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

3-23-06

10. AGE (In years last birthday)

63

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

139 W. Cross Street

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Alfred Hammock

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Akron Wissie

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

215-01-2394

18. INFORMANT

ADDRESS

Mrs. Lillie Giles 139 West Cross Street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-2 -69

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1969

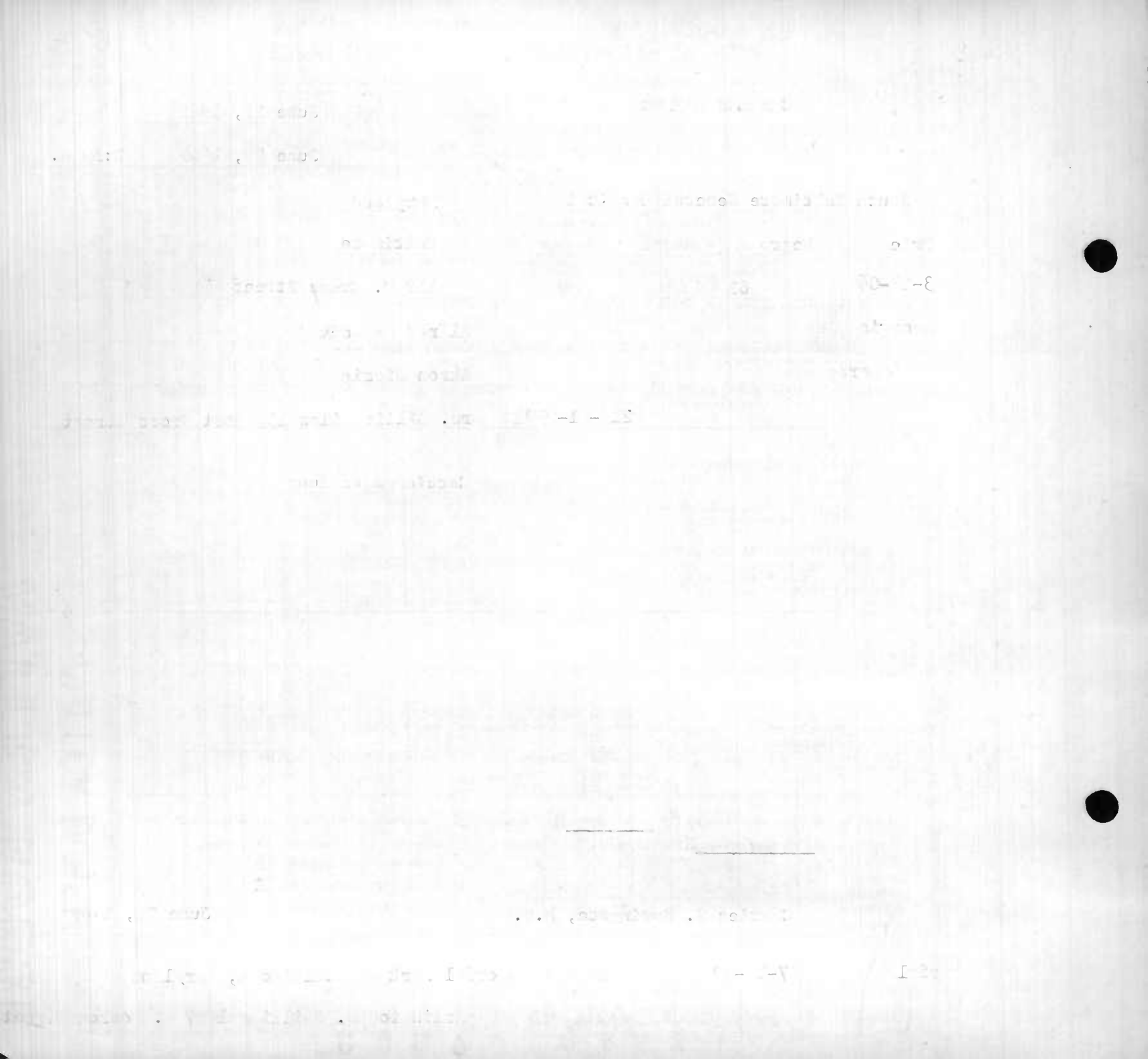
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Monroe Street

ADDRESS



69 6593

BALTIMORE CITY HEALTH DEPARTMENT

69 6593

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM BOSE, JR. (Boose)

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

June 28, 1969

4:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

Sonai Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 28, 1969

4:30 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

1510

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1-17-50

10. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3811 Barrington Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William A. Boose

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Martha Astrop

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

William A. Boose

3811 Barrington Avenue

19. 2910.10

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Drowning
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Swimming Pool

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4300 Chatam Rd. - Forrest Park School

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

6-28-69

3:45 P. M.

22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

In pool for swimming lessons

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-2-69

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT

JUL 1 1969

25B. NAME OF REGISTRAR

James E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Arlington S. Phillips 1727 N. Monroe St.

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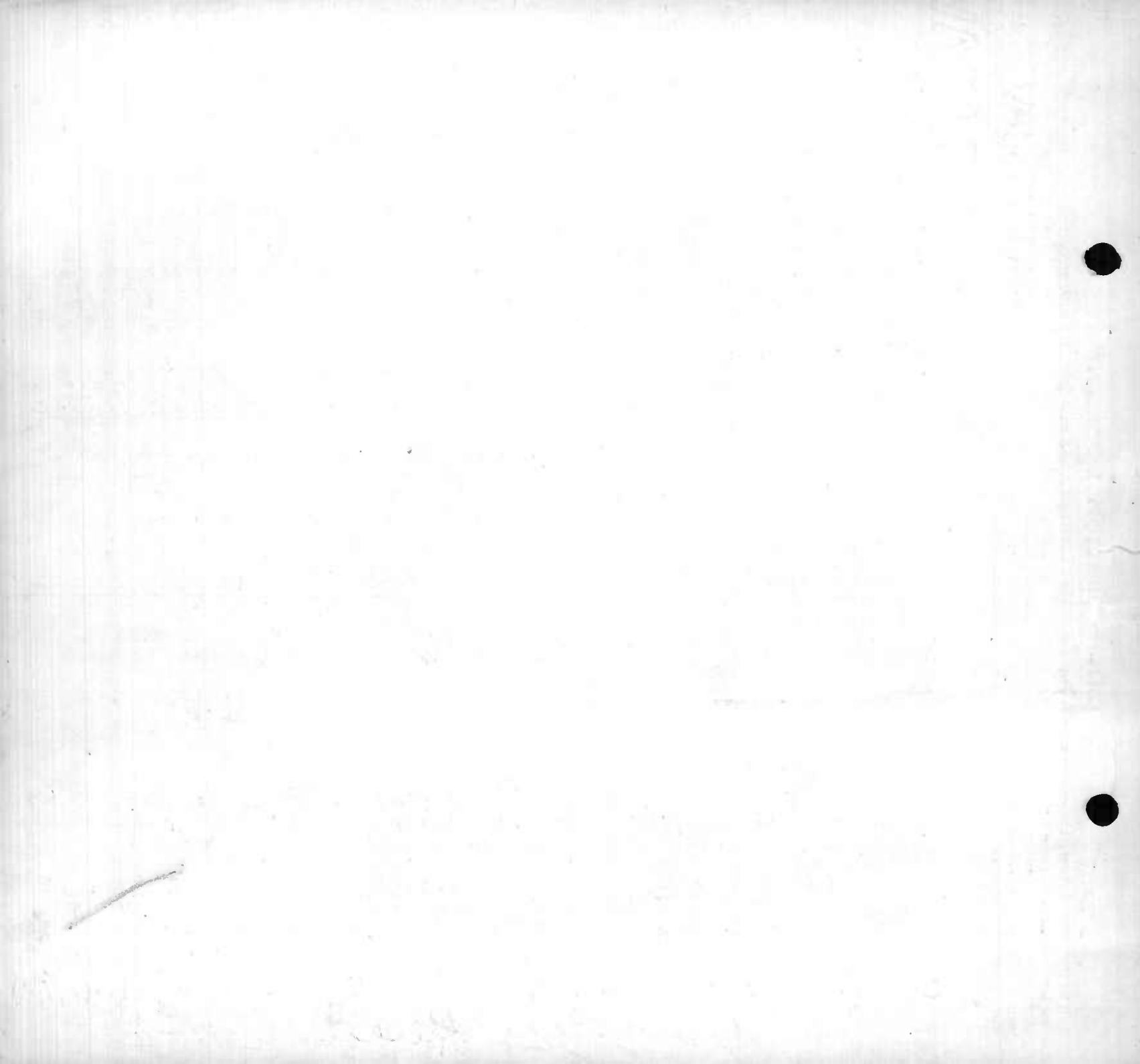
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

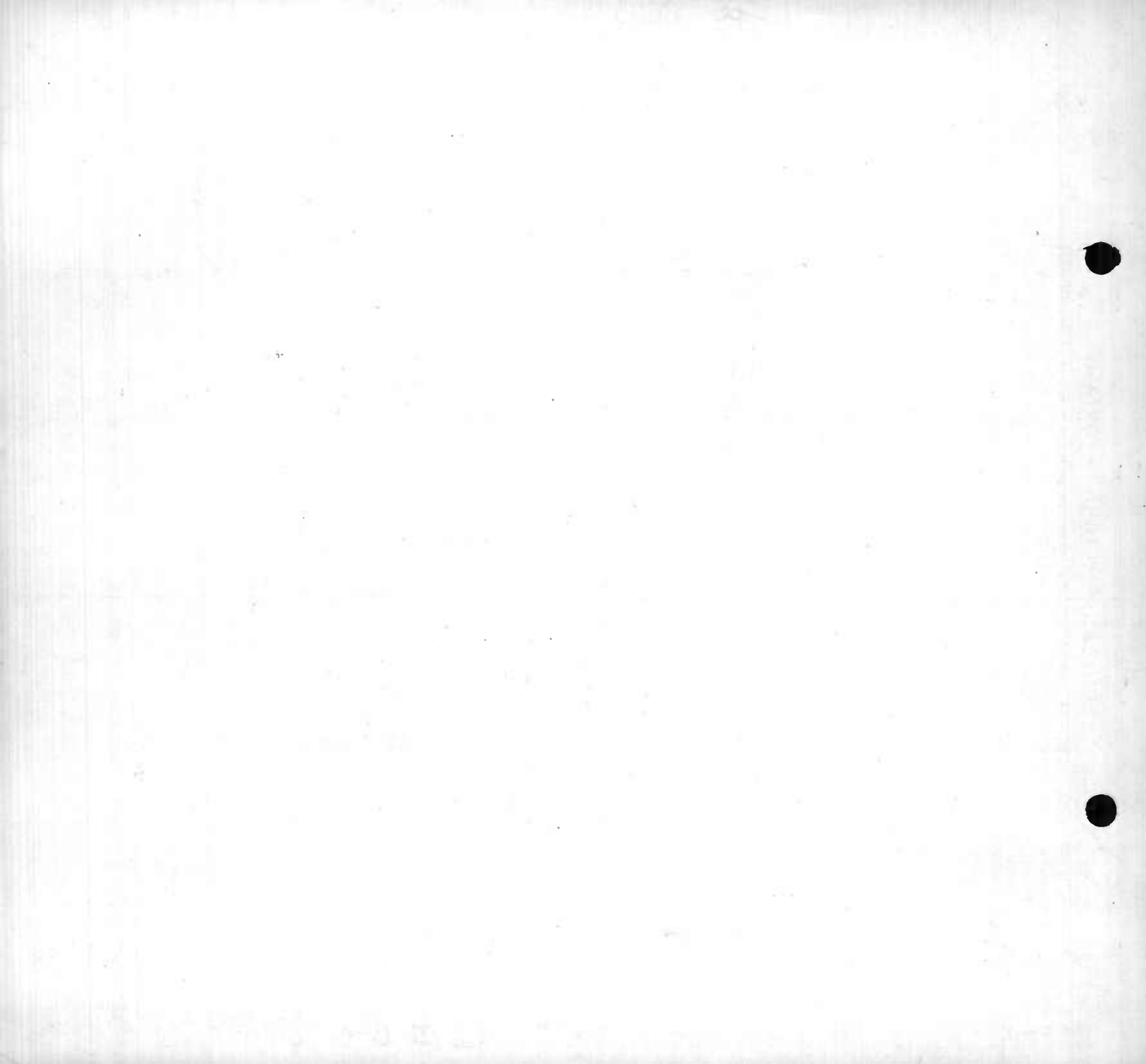
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.		69 6594	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MOZELLE PARROTT				2. DATE AND HOUR OF DEATH 6-29-69 11:47 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		AINE HUNDEL		5200			
43 SOUTH BALTO. GEN. HOSP.		3001 S. HANOVER ST		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER		BOX 121		GAILESVILLE MD	
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/13/05		9. AGE (In years last birthday) 64		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LEE THORNTON				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-32-7180		17. INFORMANT PLAZA MANOR NURS. HOME		ADDRESS 7355 FURNACE BL.			
18. 412.41		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH					
		(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cerebro Vascular Accident					
		ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Atherosclerosis					
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 6-29 19 69 to 6-29 19 69 , that (I) (we) last saw the deceased alive on 6-29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE C. Dorkan				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-29-69			
23C. PHYSICIAN'S NAME (Type) C. DORKAN		23D. ADDRESS MD 325 Hospital Drive, Glen Burnie, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME of CEMETERY or CREMATORY Cheney		24D. LOCATION (City, town, or county) (State) Gailesville, A. Q. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Robert E. Fisher		ADDRESS Glen Burnie			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6595	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Walter Jos CAGER				29 Jun 69 5⁰⁰ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Fayette Convalescent Home				C. CITY OR TOWN Elkridge D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5316 Old Lawyers Hill Rd	
5. SEX Male	6. RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-80	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Richard CAGER		14. MOTHER'S MAIDEN NAME Fannie CATHIER		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-36-9462		17. INFORMANT Walter Cager ADDRESS 21227 4304 Washington St	
18. 4124 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CHF	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				ASCVD	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Bronchial Asthma				3 mos	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 18 Apr 1969 to 29 June 1969 , that (I) (we) last saw the deceased alive on 29 June 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jaroslav Hulla M.D.				23B. DATE SIGNED 29 June 69	
23C. PHYSICIAN'S NAME (Type) Jaroslav Hulla M.D.				23D. ADDRESS 2214 E Fayette St 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-2-69		24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM. PK.	
				24D. LOCATION (City, town, or county) (State) ARBUTUS, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR 6614 Barnes St ADDRESS	



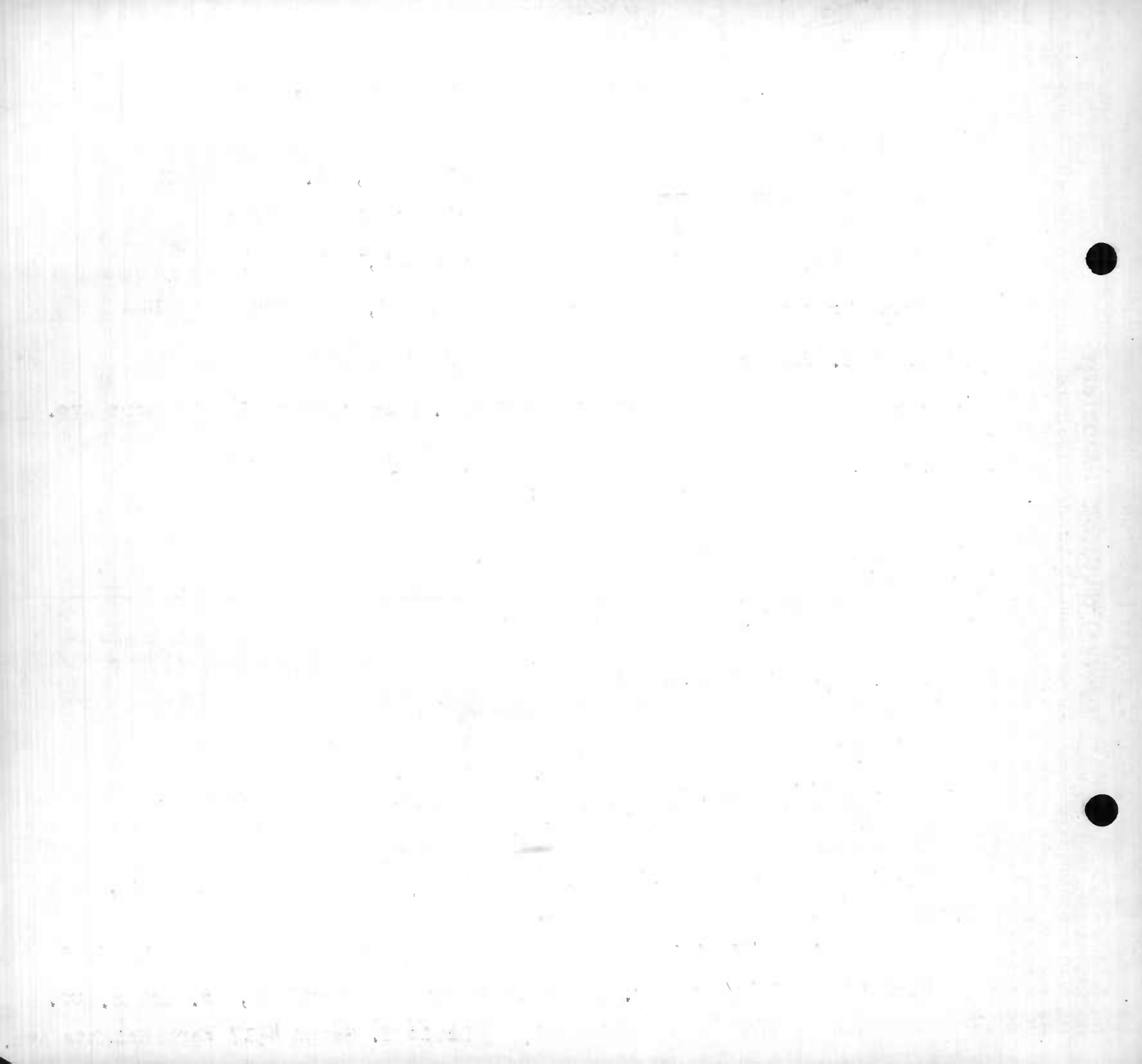
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6596	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Emma McKee		2. DATE AND HOUR OF DEATH 6/29/69 1005 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 501			
FULL NAME OF HOSPITAL OR INSTITUTION Century Nursing Home 90 102 N. Pac a St		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8/27/00 69	
11. BIRTHPLACE (State or foreign country) N.C		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years lost birthday) 69	
13. FATHER'S NAME P		14. MOTHER'S MAIDEN NAME P		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT John McKee 200 N. Aisquith St		ADDRESS	
18. 41241		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cardio Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerosis CVD DUE TO, OR AS A CONSEQUENCE OF: Genet Control Art.			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 1 19 66 to June 25 19 69 , that (I) (we) lost saw the deceased alive on June 29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE William D. Appleford		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) William D. Appleford	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/69		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY	
24D. LOCATION (City, town, or county) (State) A. A. County, Md		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Jahn, M.D.	
25C. FUNERAL DIRECTOR Locke		25D. ADDRESS 1304 N. Central Avenue			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LAWRENCE ARTHUR THOMAS		2. DATE AND HOUR OF DEATH June 28, 1969 11:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5349 Denmore Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Md. B. COUNTY 2788 C. CITY OR TOWN Baltimore, Md. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5349 Denmore Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1921 47	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Stone Quarry		11. BIRTHPLACE (State or foreign country) Hereford, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John T. Thomas			14. MOTHER'S MAIDEN NAME Mamie Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 16 9292		17. INFORMANT ADDRESS Mrs. Mary Thomas 5349 Denmore Ave.	
18. CAUSE OF DEATH 153.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinoma of Colon with Metastases (Internal lymph) (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION April 21, 1969 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstruction 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from April 14, 1969 to June 28, 1969 , that (I) (we) last saw the deceased alive on June 27, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Ernest O. Brown, M.D.				23B. DATE SIGNED June 30, 1969 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/69		24C. NAME OF CEMETERY or CREMATORY St. Lukes Cemetery	
24D. LOCATION Hereford, Md. Balto. Co.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lewis T. Gwynn 4517 Park Heights Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6598	
BIRTH NO. 69 6598		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WALTER B. SMITH		2. DATE AND HOUR OF DEATH JUNE 28, 1969, 8 ³⁰ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2759			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1116 SPRINGFIELD AVE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DANIEL A. Smith		14. MOTHER'S MAIDEN NAME SARAH JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-0841		17. INFORMANT ADDRESS Edna H. Smith, 1116 Springfield Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICKULAR FIBRILLATION (B) CONGESTIVE HEART FAILURE (C) ARTERIOSCLEROTIC HEART DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MIN. 6 WKS. YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ACUTE MYOCARDIAL INFARCTION				5 WKS.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5-24 1969 to 6-28 1969 that (1) (we) last saw the deceased alive on 6-27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Morrison Hodges MD		23B. DATE SIGNED 6/28/69		23C. PHYSICIAN'S NAME (Type) MORRISON HODGES M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/2/69		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Paek		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR John E. Fabel, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wilton Webb, 3613 Dennlyn Road	



P-632

69 6599

BALTIMORE CITY HEALTH DEPARTMENT

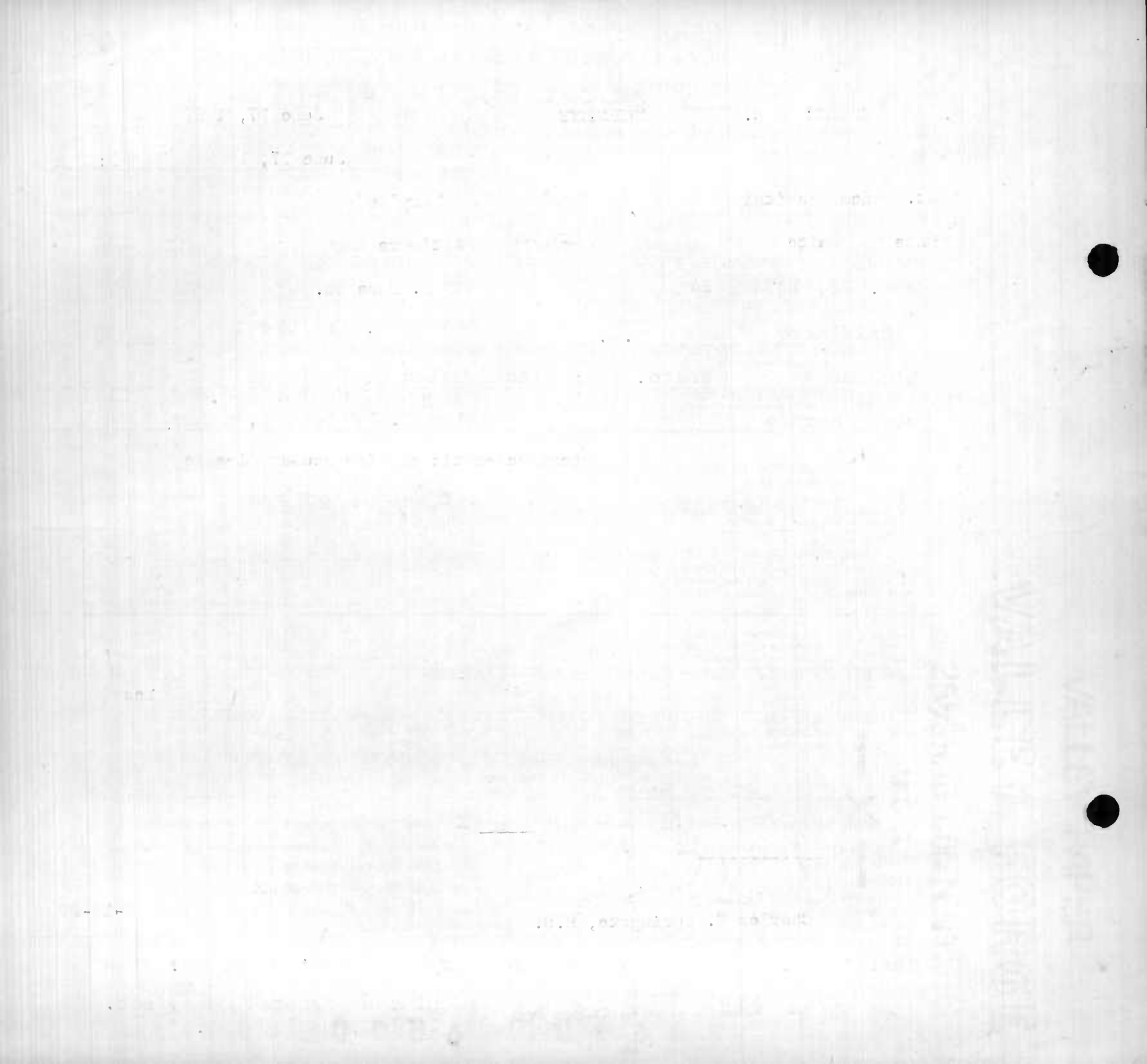
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6599

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE Clarence PRITCHETT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 27, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1969 3:10 P.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 702			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Nov. 12, 1934 34		10. AGE (In years last birthday) 34 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		14B. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec	
15. MOTHER'S MAIDEN NAME Helen E. Engle			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean		17. SOCIAL SECURITY NO.	
18. INFORMANT Helen E. Pritchett, mother		ADDRESS 5407 Hamlet Ave. 21214	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-28-69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/69	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Wm E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601 C. Madison St.	



FUNERAL DIRECTOR: IMPORTANT

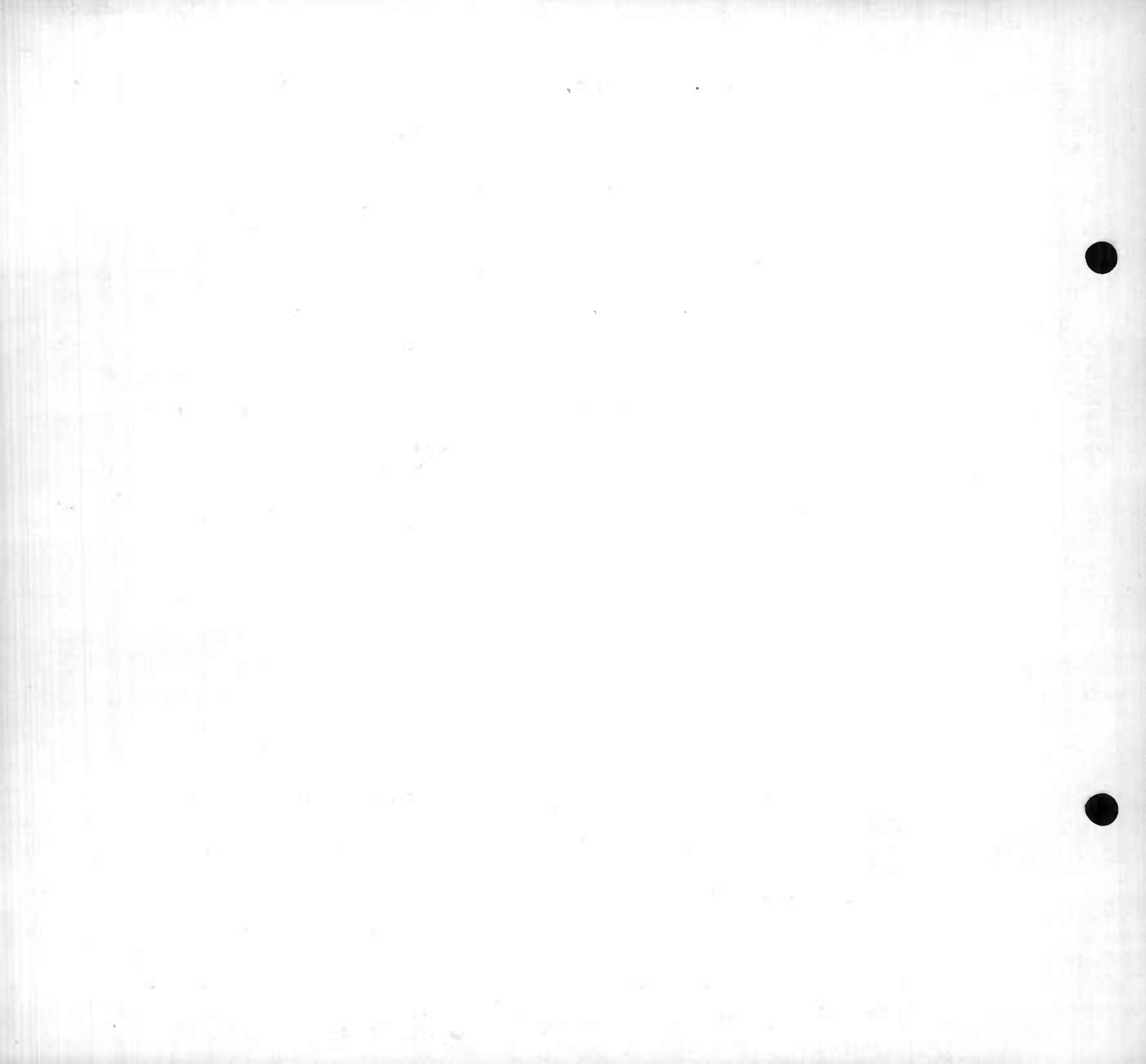
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6600

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 69 6600

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EARL H. GERKE Sr.		June 27, 1969 1 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		A. STATE Md. 21206 B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4750 Homesdale Avenue			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/03	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10B. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Edgar Gerke		14. MOTHER'S MAIDEN NAME Nora Senft			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-44-3393		17. INFORMANT ADDRESS Marie Bensel Gerke, wife, above	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 2 yrs	
		ACUTE MYOCARDIAL INFARCTION			
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic disease			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1968 January 1968 to June 1969, that (I) (we) last saw the deceased alive on April 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham Benecim		23B. DATE SIGNED 28 June 1969			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 611 Park Ave Balt Md 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/1/69	24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Sabers, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schiffman Funeral Home, Inc. 3331 Brehms Lane	



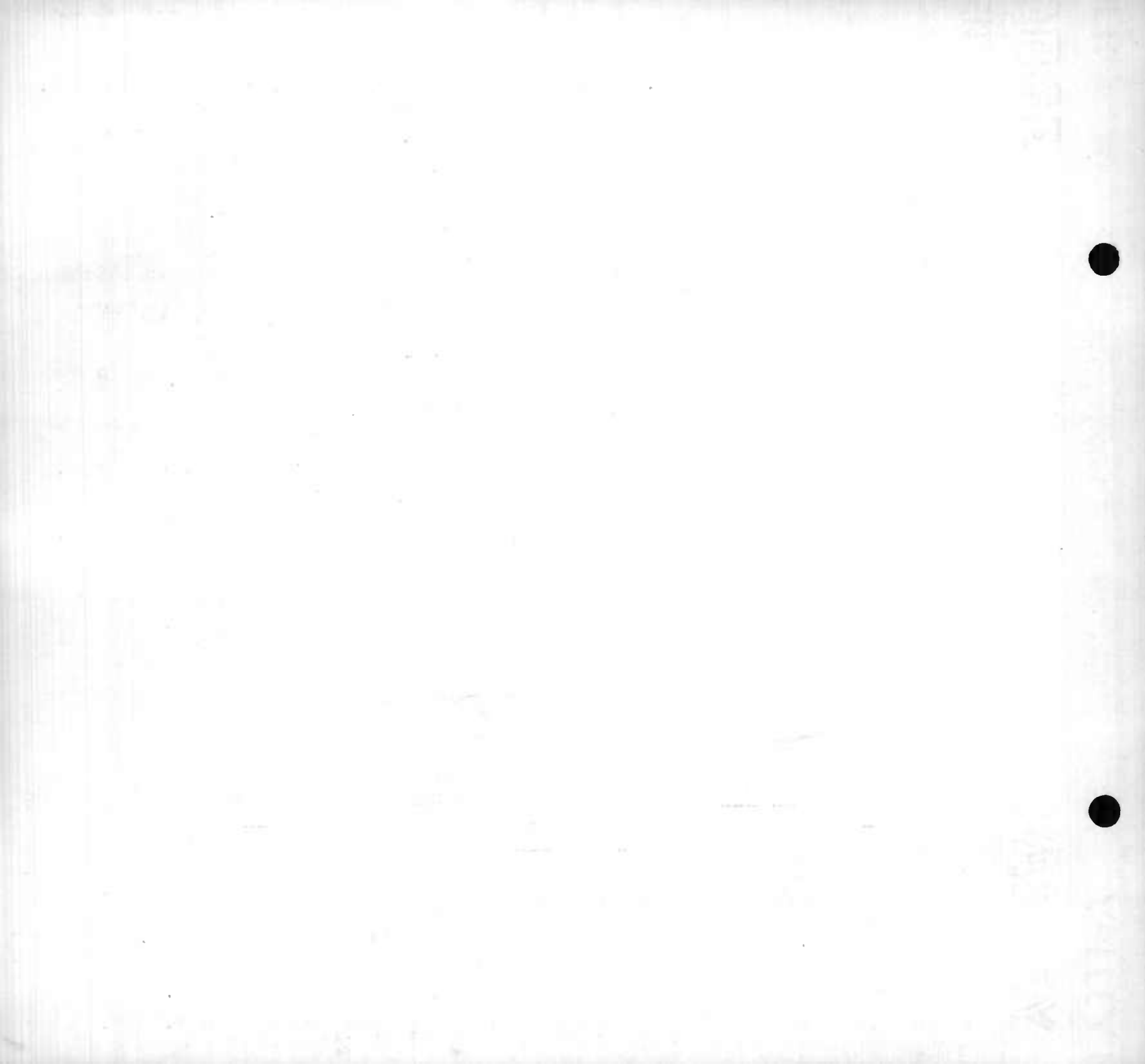
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6601 CERTIFICATE OF DEATH

REG. NO. 69 6601

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOUISE M. MEHL		June 27, 1969 12:25 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md. 1338	
90 Ardleigh Nursing Home				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2095 Rockrose Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/6/79	90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		at home		Germany	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
unknown			Germany		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			216-52-1374		
17. INFORMANT			ADDRESS		
Gilbert H. Alfred, friend			1004 Cloverlea Rd. 21204		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease 15 yrs. (B) Hypertension 15 yrs. (C)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 19 63 to June 27, 19 69, that (I) (we) last saw the deceased alive on June 25, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lloyd E. Saylor, M.D.				June 30, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Lloyd Saylor				3902 Greenmount Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/30/69		Holy Redeemer Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 1 1969		Robert E. Taber, R.D.		Schimunek Funeral Home, Inc.	
				ADDRESS 6330 Briggs Lane	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6602

BIRTH NO. 67-06587

1. NAME OF DECEASED (Type or Print) Allen DAVID JURATOVAC

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ June 28, 1969 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
June 28, 1969 10:30 A.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 7026. SEX Male 7. RACE White 8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☐9. DATE OF BIRTH 4/1/67 10. AGE (In years lost birthday) 2
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER 835 N. Milton

11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Loring Smith

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME Jacqueline Evan

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS Jacqueline Juratovac, mother, above

19. CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Cerebro-cranial injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

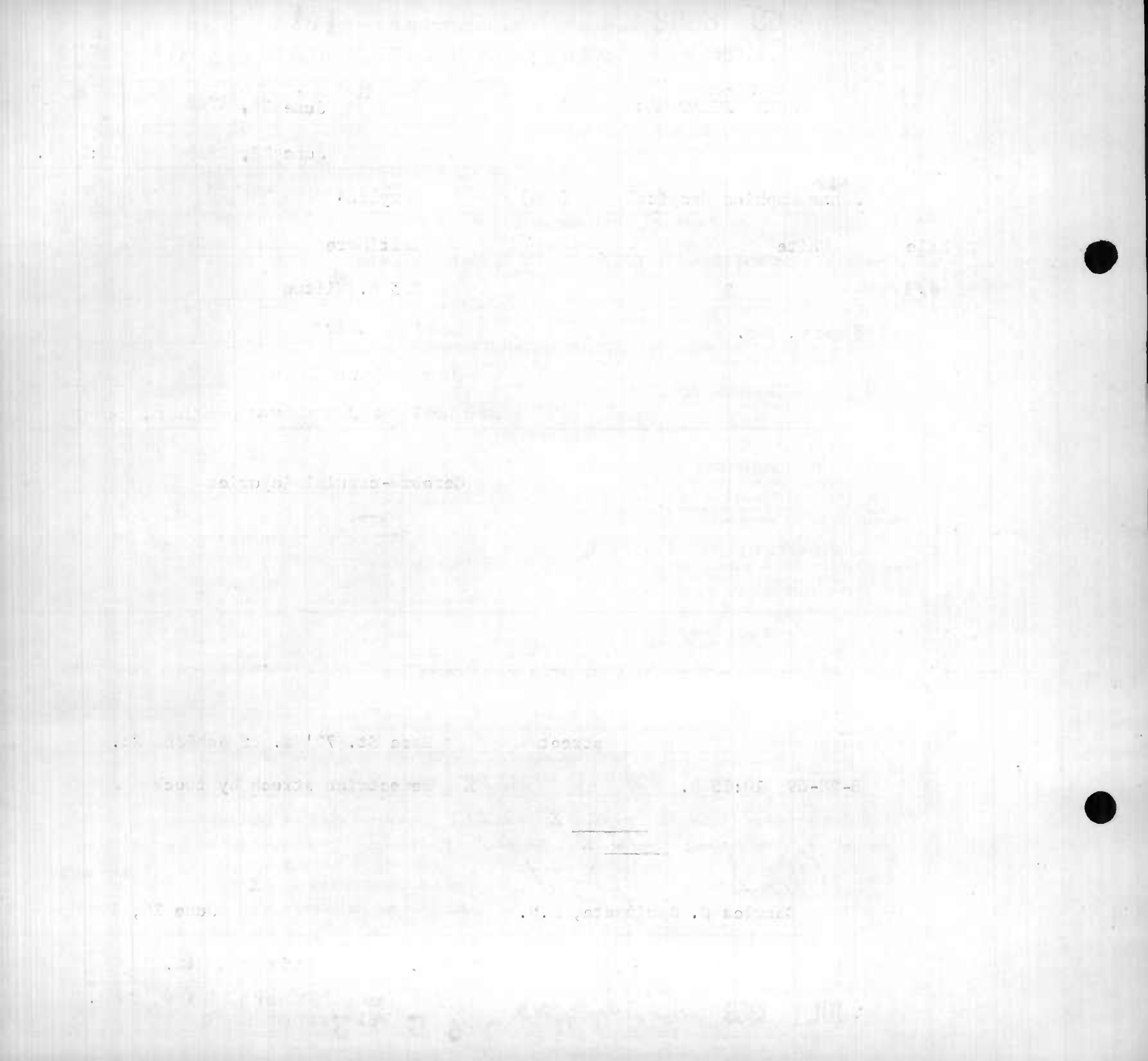
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rose St. 72' S. of Ashland St. 70222D. TIME OF INJURY (APPROX.) 6-28-69 10:15 A. m. 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Pedestrian struck by truck23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED
ASSOCIATE MEDICAL EXAMINER ☐ June 29, 1969

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 6/30/69 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 5331 Brehms Lane



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		69 6603 CERTIFICATE OF DEATH				Registered No. 69 6603			
1. NAME OF DECEASED (Type or Print) JACOB E. EBAUGH						2. DATE AND HOUR OF DEATH 6/25/69 12⁰⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convalesarium 6116 Bel Air Rd.						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Phoenix D. STREET ADDRESS (If rural, give location) Sweet Air Rd.			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH May 26, 1889		9. AGE (In years, months, days) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Frat. Lenductor				10B. KIND OF BUSINESS OR INDUSTRY Penna R.R.		11. BIRTHPLACE (State or foreign country) York Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Ebaugh						14. MOTHER'S MAIDEN NAME Mary Butcher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 77-07-8312		17. INFORMANT Mrs. Helen Sines				ADDRESS Phoenix, Md. 21131	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 188X I						CAUSE OF DEATH (A) Generalized Internal Bleeding DUE TO (B) Uremia DUE TO (C) Carcinoma of the Bladder		INTERVAL BETWEEN ONSET AND DEATH 2 days months months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cobalt Therapy						weeks			
19A. DATE OF OPERATION 6/20/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/20/19 69 to 6/27/19 69 , that (I) (was) last saw the deceased alive on 6/24/19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.									
23A. SIGNATURE Albert B. Bradley						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/25/69	
23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D.						23D. ADDRESS 4900 BELAIR ROAD 21206			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/69		24C. NAME OF CEMETERY OR CREMATORY New Freedom Cemetery		24D. LOCATION (City, town, or county) (State) New Freedom, Penna.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR John E. Ebaugh, M.D.		25C. FUNERAL DIRECTOR John E. Ebaugh, M.D.		ADDRESS New Freedom, Pa.			

Mr. J. H. Jones
The owner
West Air Rd

Mr. J. H. Jones
The owner
West Air Rd

May 1900
J. H. Jones
West Air Rd

Male White Married
J. H. Jones
West Air Rd

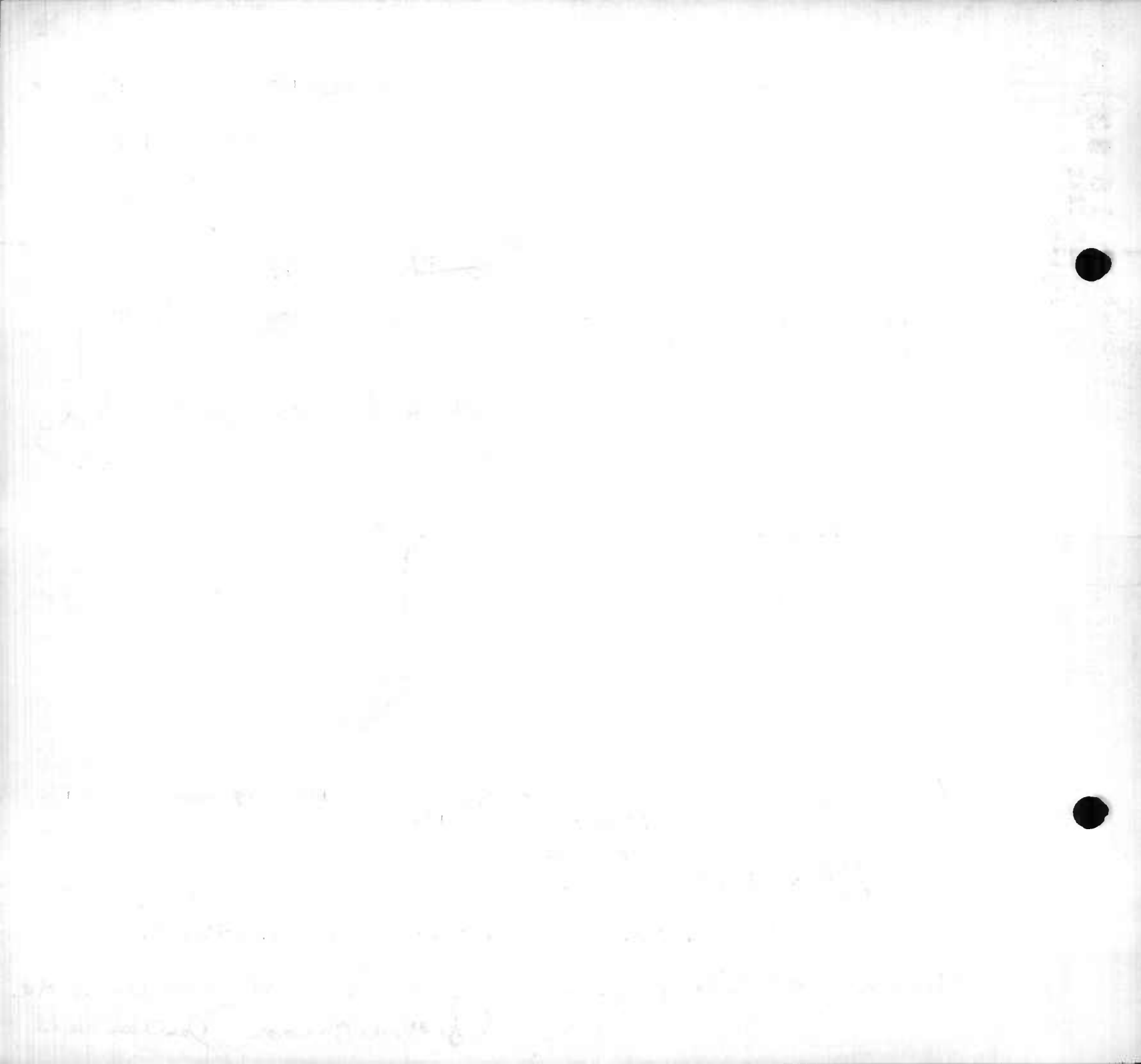
May 1900
J. H. Jones
West Air Rd

May 1900
J. H. Jones
West Air Rd

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

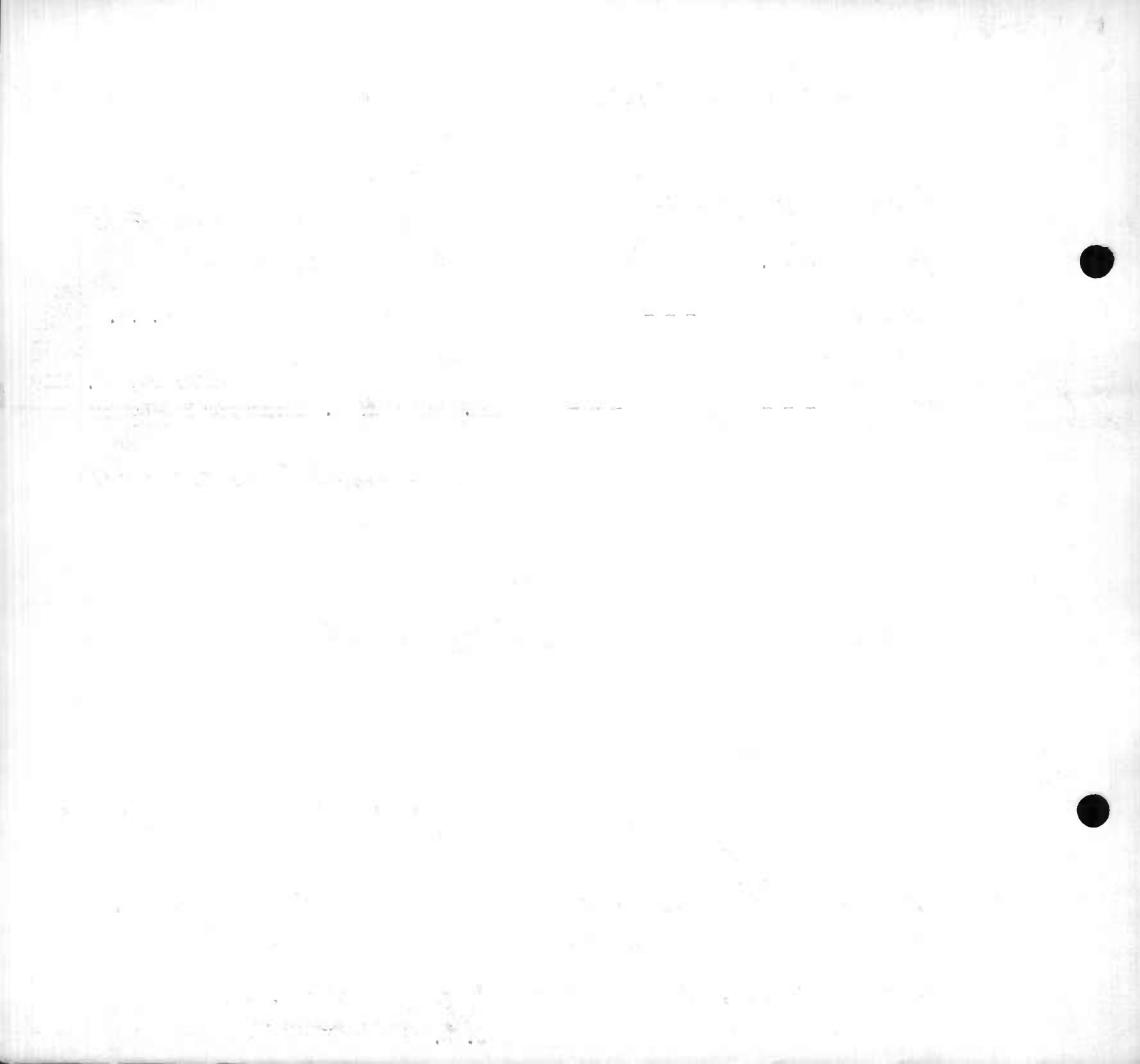
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 6604	
BIRTH NO. F655		1. NAME OF DECEASED (Type or Print) Zeke Forman			
2. DATE AND HOUR OF DEATH 27 June '69 3:05 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY BALTIMORE CAROLINE CITY 55-00		5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MALE NEGRO			
8. DATE OF BIRTH 3-21-23		9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ISAIAH FORMAN	
14. MOTHER'S MAIDEN NAME PEARL BUTLER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Alice Brown, Denton, Md.		ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH sepsis (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
19A. DATE OF OPERATION 22		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 June '69 to 27 June '69 that (I) (we) last saw the deceased alive on 27 June '69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Norum, M.D.				23B. DATE SIGNED 27 June '69	
23C. PHYSICIAN'S NAME (Type) Robert A. Norum, M.D.				23D. ADDRESS Johns Hopkins Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1, 1969		24C. NAME OF CEMETERY OR CREMATORY Hope Churchyard	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969			
25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles H. Moore, Denton, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

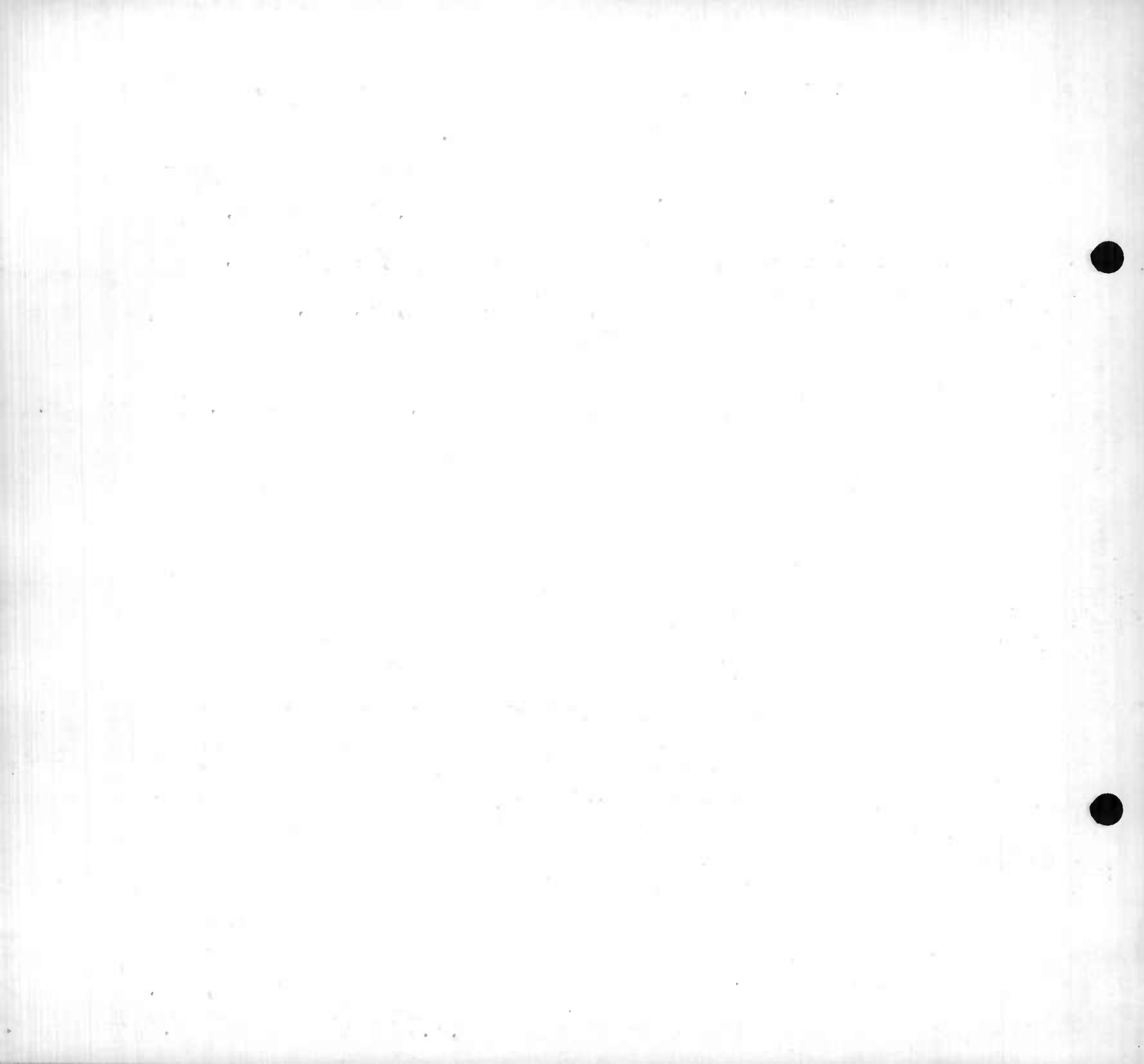
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6605</u>	
69 6605 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>E. dna Hilgartner</u>		2. DATE AND HOUR OF DEATH <u>6-26-69</u> <u>11 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>42 Sinai Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2716</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>			6. RACE <u>CAUC.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>4-8-78</u>		9. AGE (In years last birthday) <u>89</u> <u>82</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Fred Schmelz</u>			14. MOTHER'S MAIDEN NAME <u>Margaret ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Baltimore, Md. 21090</u> <u>Mr. Frederick O. Hilgartner 308 Jerlyn Avenue</u>	
18. CAUSE OF DEATH <u>4-10-91-23-0.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Mxocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>diabetes mellitus</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4:30 PM 6-19 1969</u> to <u>11 PM 6-26 1969</u> that (I) (we) last saw the deceased alive on <u>6-26 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Martin S. Liberman M.D.</u>				23B. DATE SIGNED <u>6-26-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARTIN S. Liberman M.D.</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 30, 1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>			
25B. NAME OF REGISTRAR <u>Walter E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. E. Lowell Lemmon</u>			
ADDRESS <u>4611 Park Heights Avenue</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6606	
1. NAME OF DECEASED (Type or Print) BERTHA M. HUFFMAN			2. DATE AND HOUR OF DEATH JUNE 27, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1101		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 60205 E. PRESTON ST.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 205 E. PRESTON ST.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14/92	9. AGE (In years last birthday) 77 YRS.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) THOMAS, W. VA.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT JOHN L. HUFFMAN
					ADDRESS 205 E. PRESTON ST.
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Anoxia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) A.S.C.V. Disease DUE TO, OR AS A CONSEQUENCE OF:		?
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/3 19 65 to 6/27/69 , that (I) (we) last saw the deceased alive on 6/4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum MD				23B. DATE SIGNED 6/28/69	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD				23D. ADDRESS 1115 N. CALVERT ST.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/1/69		24C. NAME of CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION BALTIMORE, MD.		24E. FUNERAL DIRECTOR H. W. MEARS & SON			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Garber, MD.		25C. ADDRESS 805 N. CALVERT ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

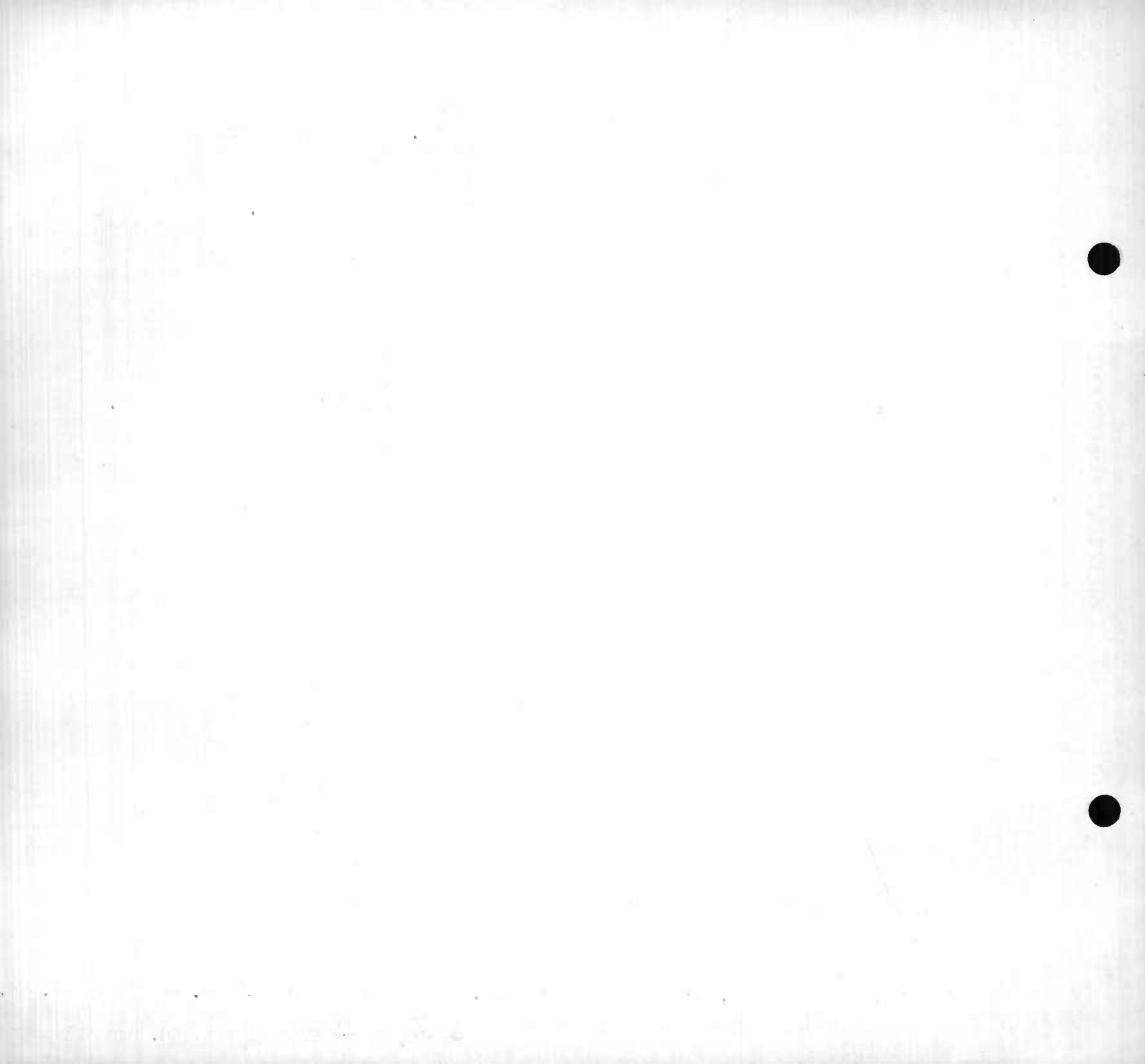
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6607	
69 6607 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William J. Malooly</i>		2. DATE AND HOUR OF DEATH <i>6-26-69 6:05 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Ma. General Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>City</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Ma. General Hospital</i>			C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1615 Ingram Rd 21212</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-14-92</i>	9. AGE (in years last birthday) <i>77</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>William F. Malooly</i>		
14. MOTHER'S MAIDEN NAME <i>Catherine Lynch</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <i>NO</i>		
16. SOCIAL SECURITY NO. <i>217-07-6981</i>			17. INFORMANT <i>Anne K. Malooly (wife)</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>
(B) <i>Carcinoma of Cecum</i> DUE TO, OR AS A CONSEQUENCE OF:			(C)		
19A. DATE OF OPERATION <i>6/18/69</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>intestinal Obstruction</i>		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <i>6/18/69</i> 19 to <i>6/26/69</i> 19 that (2) (we) lost saw the deceased alive on <i>6/26/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joel P. Baker M.D.</i>			23B. DATE SIGNED <i>6/26/69</i>		23C. PHYSICIAN'S NAME (Type) <i>JOEL P. BAKER</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>6/30/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cem.</i>
24D. LOCATION <i>Baltimore Co. Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1969</i>		
25B. NAME OF REGISTRAR <i>Joel P. Baker, M.D.</i>			25C. FUNERAL DIRECTOR <i>C. F. EVANS & SON</i>		
25D. ADDRESS <i>8802 Harford road</i>					



FUNERAL DIRECTOR: IMPORTANT

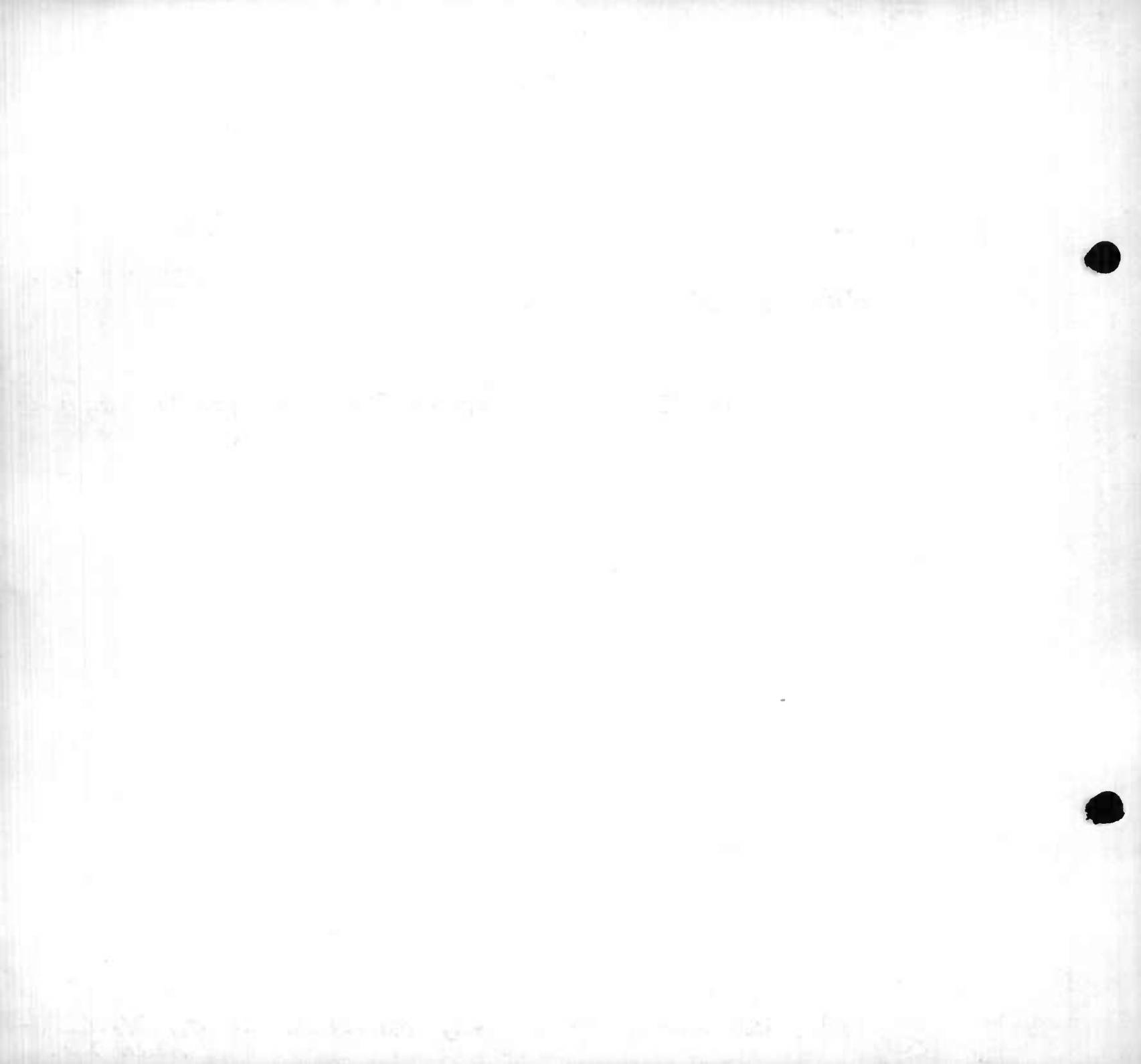
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6608	
BIRTH NO. 69-11568		69 6608 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY GIRL STILL		2. DATE AND HOUR OF DEATH JUNE 28 1969 12:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5300			
FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL		C. CITY OR TOWN Randallstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 357 Marriottsville Rd.			
5. SEX F	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27, 1969	9. AGE (In years last birthday) 11	10. Under 24 Hrs. Min. 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNITED STATES	
13. FATHER'S NAME GEORGE STILL		14. MOTHER'S MAIDEN NAME MARIANNE LOUISE STARKEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS George Still 357 Marriottsville Rd.	
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Irradiation (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ...			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-27 1969 to 6-28 1969, that (I) (we) last saw the deceased alive on 6-28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Estrellita P. Trias M.D.		23B. DATE SIGNED 6-28-69		23C. PHYSICIAN'S NAME (Type) ESTRELLITA P. TRIAS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 69		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.	
24D. LOCATION Windsor Mill Rd. Baltimore Co. Md.		24E. NAME OF REGISTRAR JUL 1 1969		24F. FUNERAL DIRECTOR ADDRESS George E. Byers 8728 Liberty Rd. Randallstown	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 69 6609	
BIRTH NO. 69 6609		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Kidwell, George A.</i>		2. DATE AND HOUR OF DEATH <i>6/28/68</i> <i>5:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2582</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1928 Parkley Ave. - (21230)</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED <i>Married</i> DIVORCED (specify)	8. DATE OF BIRTH <i>1/4/95</i>	9. AGE (In years lost birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BOARD - Maryland Glass</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>JAMES KIDWELL</i>			14. MOTHER'S MAIDEN NAME <i>SARAH FONTZ</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>1918-1919</i>		16. SOCIAL SECURITY NO. <i>217013841</i>		17. INFORMANT ADDRESS (21230) <i>Mr. Albert Kidwell 1928 Parkley Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>CHF - Hypertension</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Emphysema</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>ASCVD</i>			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/16/68</i> 19 <i>68</i> to <i>6/28/68</i> 19 <i>68</i> that (I) (we) last saw the deceased alive on <i>6/28/68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Surinder</i> M.D.				23B. DATE SIGNED <i>6/28/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>SURINDER</i>		23D. ADDRESS <i>F.S. Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/69</i>		24C. NAME of CEMETERY or CREMATORY <i>Green Haven Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Blonharne, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Tabor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John P. Leonard & Son, Inc. 901 Hollins St. Balto. Md.</i>	

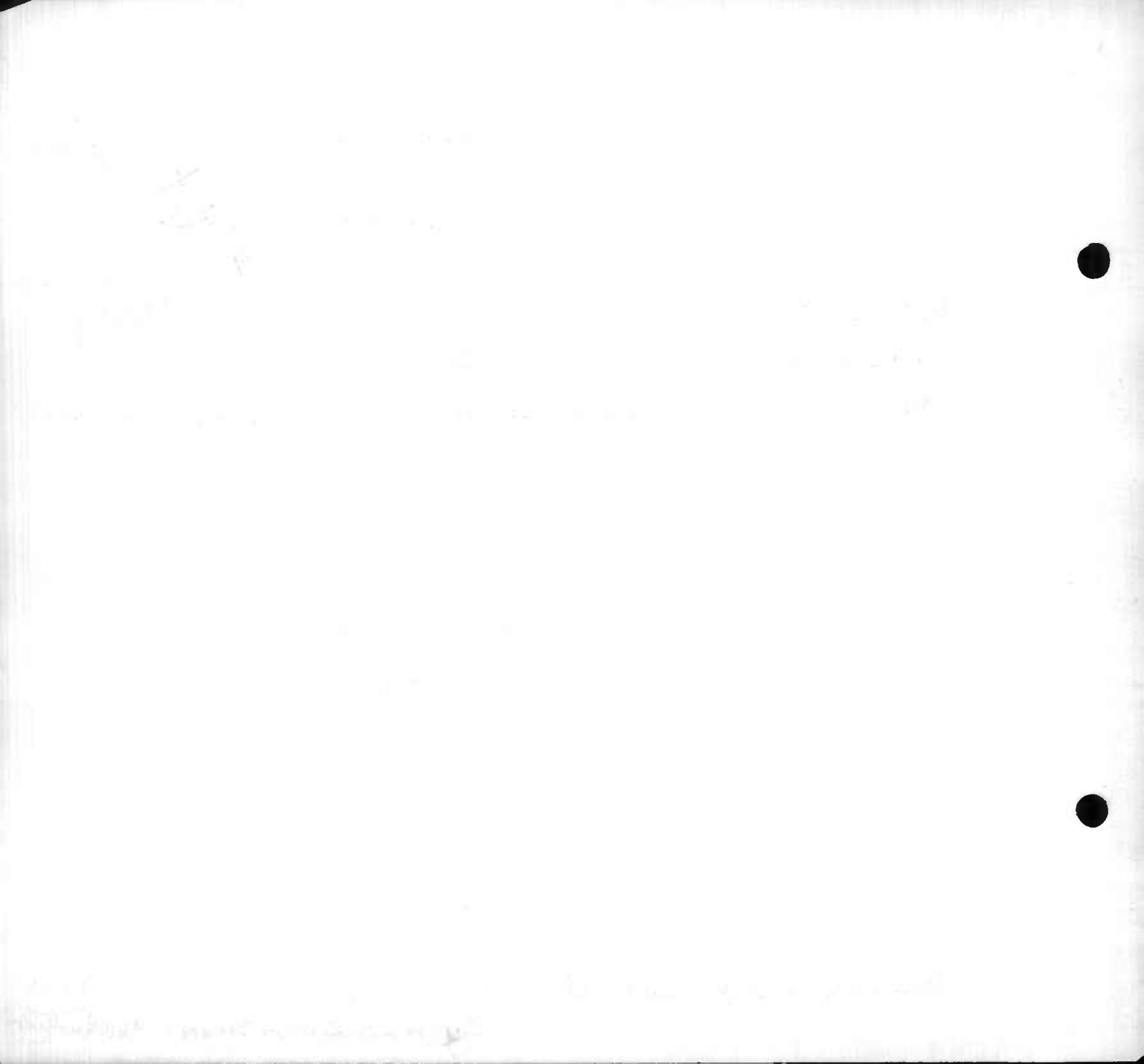


NOTE: Attending physician Dr. Manuel Levin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 6610		69 6610		69 6610	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HARRY SHULMAN		2. DATE AND HOUR OF DEATH 2:15 AM 6-29-69			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTO MD. C. CITY OR TOWN BALTO MD. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5706 Rockspring Rd 2755			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/90	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Jeweler		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME Isaac		14. MOTHER'S MAIDEN NAME Sarah		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-4263		17. INFORMANT Mrs Mollie Shulman	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GRAM NEGATIVE SEPSIS AND ACUTE UREMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD, CEREBROVASCULAR DISEASE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/25 19 69 to 6/29 19 69 that (I) (we) last saw the deceased alive on 6/29 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gian Caggiano MD		23B. DATE SIGNED 6/29/69		23C. PHYSICIAN'S NAME (Type) GIAN CAGGIANO	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/69		24C. NAME of CEMETERY or CREMATORY Adas Israel	
24D. LOCATION Balto		24E. NAME of REGISTRAR Robert E. Fisher, M.D.		24F. FUNERAL DIRECTOR Sylvanus Lewis Samin	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Sylvanus Lewis Samin	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 69 6611	
BIRTH NO. 69 6611		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SULLIVAN, VANCE RICHMOND		2. DATE AND HOUR OF DEATH 6/27/69 6:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Lutherville D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 102 Greenridge Rd.		5. SEX M 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HEALTH INSPECTOR-RET. HEALTH DEPT.		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 7/16/09 9. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Arthur L. Sullivan	
14. MOTHER'S MAIDEN NAME Evelyn L. Richmond		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FAMILY RECORDS		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Gram Negative Sepsis		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Pseudomonas Pneumonia 10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		Prolonged course on respirator due to CVA 5 wks.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). d) Bleeding Peptic ulcer & Surgery x 2		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
19A. DATE OF OPERATION 5/17 - 5/27/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Johns Hopkins Hospital, Dept Surgery	
22. I certify that (I) (this hospital) attended the deceased from 5/14 1969 to 6/27 1969 , that (I) (we) last saw the deceased alive on 6/27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Michael B. Marchildon, MD			
23B. DATE SIGNED 6/27/69		23C. PHYSICIAN'S NAME (Type) Michael B. Marchildon			
23D. ADDRESS JHH The Johns Hopkins Hospital Dept Surgery		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE JUN. 30, 1969		24C. NAME OF CEMETERY or CREMATORY GOVANS PRESBYTERIAN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR James E. Spiller, M.D.		25C. FUNERAL DIRECTOR John Darré, Son, Towson, Md.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6612
REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

STEVEN K. POWERS

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

June 28, 1969

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

3. DATE

Month

Day

Year

Hour

M.

June 28, 1969

10:45 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

BALTO 5300

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Essex

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

FEB. 25, 1951

10. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

604 Franklin Avenue

11. BIRTHPLACE (State or foreign country)

MICH.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

GEO. M. POWERS

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MACH. SCHOOL

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

SHIRLEY MYERS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

17. SOCIAL
SECURITY NO.

18. INFORMANT

CHARLES POWERS

ADDRESS

ABOVE

19. E910.10

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Drowning
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Swimming Pool

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1711 Glencurtis

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 6-28-69 10:09 P.m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Playing in pool

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7/2/69

24C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITH

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1969

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

J.G. CANNELLY

ADDRESS

300 MACE

UNITED STATES
DEPARTMENT OF AGRICULTURE

STATION

EXHIBIT

NO. 1

GEORGE M. POWERS

U.S.A.

WASH.

SHIRLEY POWERS

~~SHIRLEY POWERS~~

CHIEF POWER

UNIT

12

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

UNITED STATES

DEPARTMENT OF AGRICULTURE

STATION

SHIRLEY POWERS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>69 6613</u>
BIRTH NO. <u>69 6613</u>				
1. NAME OF DECEASED (Type or Print) <u>ARMEL, Benjamin Harrison</u>		2. DATE AND HOUR OF DEATH <u>June 28, 1969</u> <u>4:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>292 Edgewater Apartments</u>		
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-89</u>	9. AGE (In years last birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Jesse Armel</u>		
14. MOTHER'S MAIDEN NAME <u>Minnie Border</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes 9-19-17 to 6-7-19</u>		
16. SOCIAL SECURITY NO. <u>225-709-8836</u>		17. INFORMANT <u>Records V. A. Hospital</u> ADDRESS <u>3900 Loch Raven Blvd., Baltimore, Md. 21218</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Probable cerebral thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>SHD & ASCVD</u>		
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Tbc</u>		
		(C) <u>Fracture of left femur</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Fracture of left femur</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
19A. DATE OF OPERATION <u>6/21/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SHD & ASCVD</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>292 Edgewater V.A. Hospital</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>6/21/69</u> <u>3:25 P</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>accidentally fall</u>
22. I certify that <u>NY</u> (this hospital) attended the deceased from <u>May 12,</u> 19 <u>69</u> to <u>June 28,</u> 19 <u>69</u> that <u>NY</u> (we) last saw the deceased alive on <u>June 28,</u> 19 <u>69</u> and that <u>NY</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>NY</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Salah m. Nasrallah</u>				23B. DATE SIGNED <u>6-28-69</u>
23C. PHYSICIAN'S NAME (Type) <u>Salah Nasrallah</u>		23D. ADDRESS <u>V. A. Hospital</u> <u>3900 Loch Raven Blvd., Baltimore, Md. 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>7/2/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT. CEM.</u>	24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Talbot, M.D.</u>	25C. FUNERAL DIRECTOR <u>J. G. CONNELLY SONS</u> ADDRESS <u>300 MAC</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

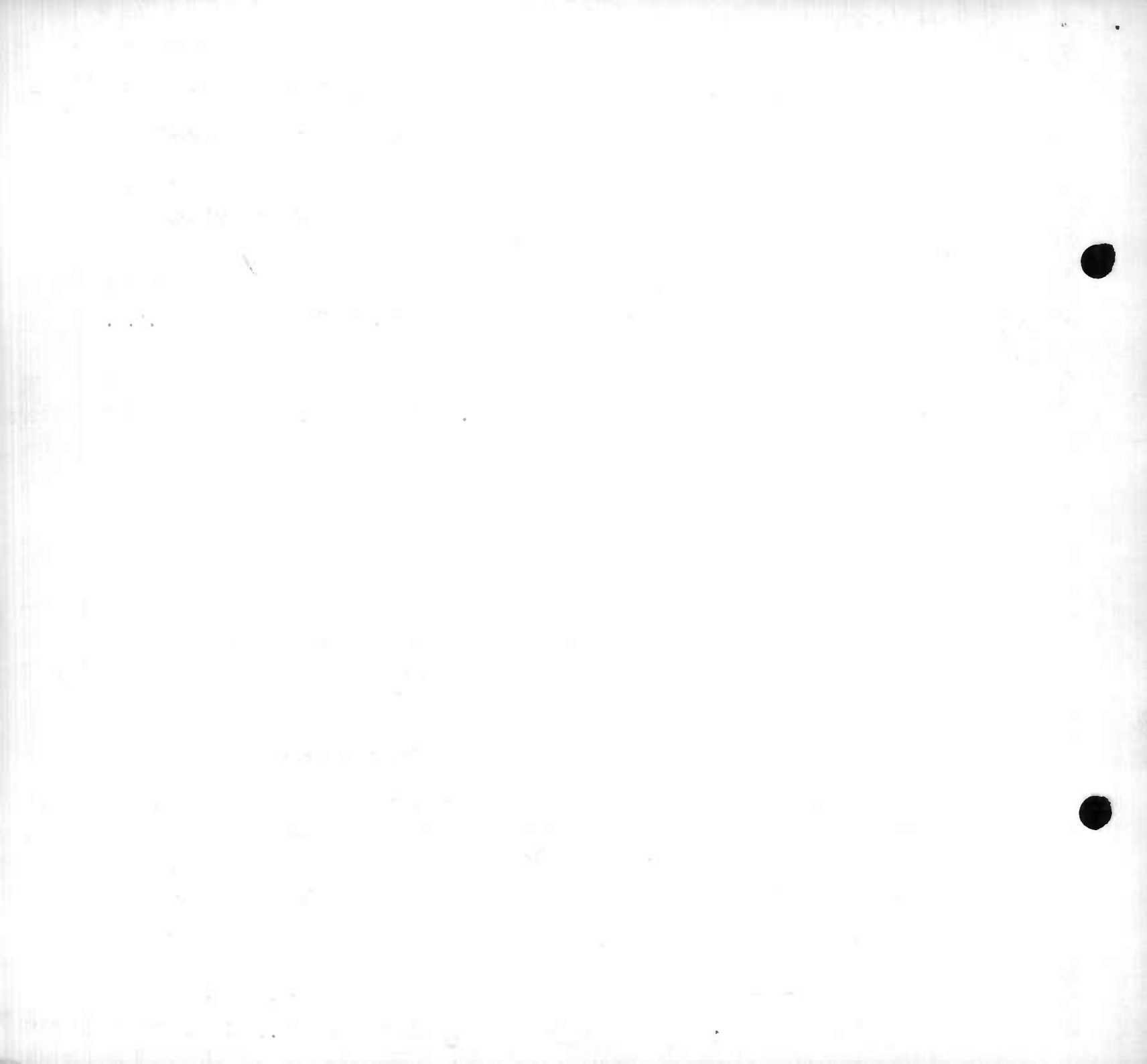
BALTIMORE CITY HEALTH DEPARTMENT 69 6614 CERTIFICATE OF DEATH				REG. NO. 69 6614	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WOOLFORD, Holland		2. DATE AND HOUR OF DEATH JUNE 24 1969 7³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Princess Anne		C. CITY OR TOWN Princess Anne D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER Rt. 3, Box 72-B	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/51	9. AGE (in years lost birthday) 18	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Walton Woolford		14. MOTHER'S MAIDEN NAME Frances V. Holbrook	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frances Woolford Princess Anne, MD	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) VENTRICULAR SEPTAL DEFECT with Intractable Congestive heart Failure		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR SEPTAL DEFECT with Intractable Congestive heart Failure		18 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Failure		2 months	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 22 1969 to June 24 1969 that (I) (we) last saw the deceased alive on June 23 1969 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Olson, M.D.		23B. DATE SIGNED June 24, 1969		23C. PHYSICIAN'S NAME (Type) M. Olson, M.D.	
23D. ADDRESS The Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6/27/69		24C. NAME OF CEMETERY or CREMATORY Grace		24D. LOCATION (City, town, or county) (State) Venton, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Talbot, M.D.		25C. FUNERAL DIRECTOR W. H. James	
25D. ADDRESS Princess Anne					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-632		69 6615		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6615	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ROSE HORWITZ</u>				2. DATE AND HOUR OF DEATH <u>28 JUNE 1969</u> <u>5 45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital of Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4601 Pall Mall Road.</u>			
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/6/07</u>	9. AGE (in years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AARON HORWITZ</u>				14. MOTHER'S MAIDEN NAME <u>ELLA MEYEROWITZ</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. GUSSIE SIEGEL, 8202 ARODENE ROAD #21208</u>			
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Gastrointestinal bleeding secondary to duodenal ulcer</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>20 JUNE 1969</u> to <u>28 JUNE 1969</u> that (we) last saw the deceased alive on <u>28 JUNE 1969</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <u>not</u> view the body after death.							
23A. SIGNATURE <u>Morris Ostroff, MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>28 JUNE 1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>MORRIS Ostroff, MD</u>				23D. ADDRESS <u>Sinai Hospital of Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-30-69</u>		24C. NAME of CEMETERY or CREMATORY <u>OHEL YAKOV BETH ISRAEL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>James E. Jaber, MD.</u>		25C. FUNERAL DIRECTOR <u>SOB LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

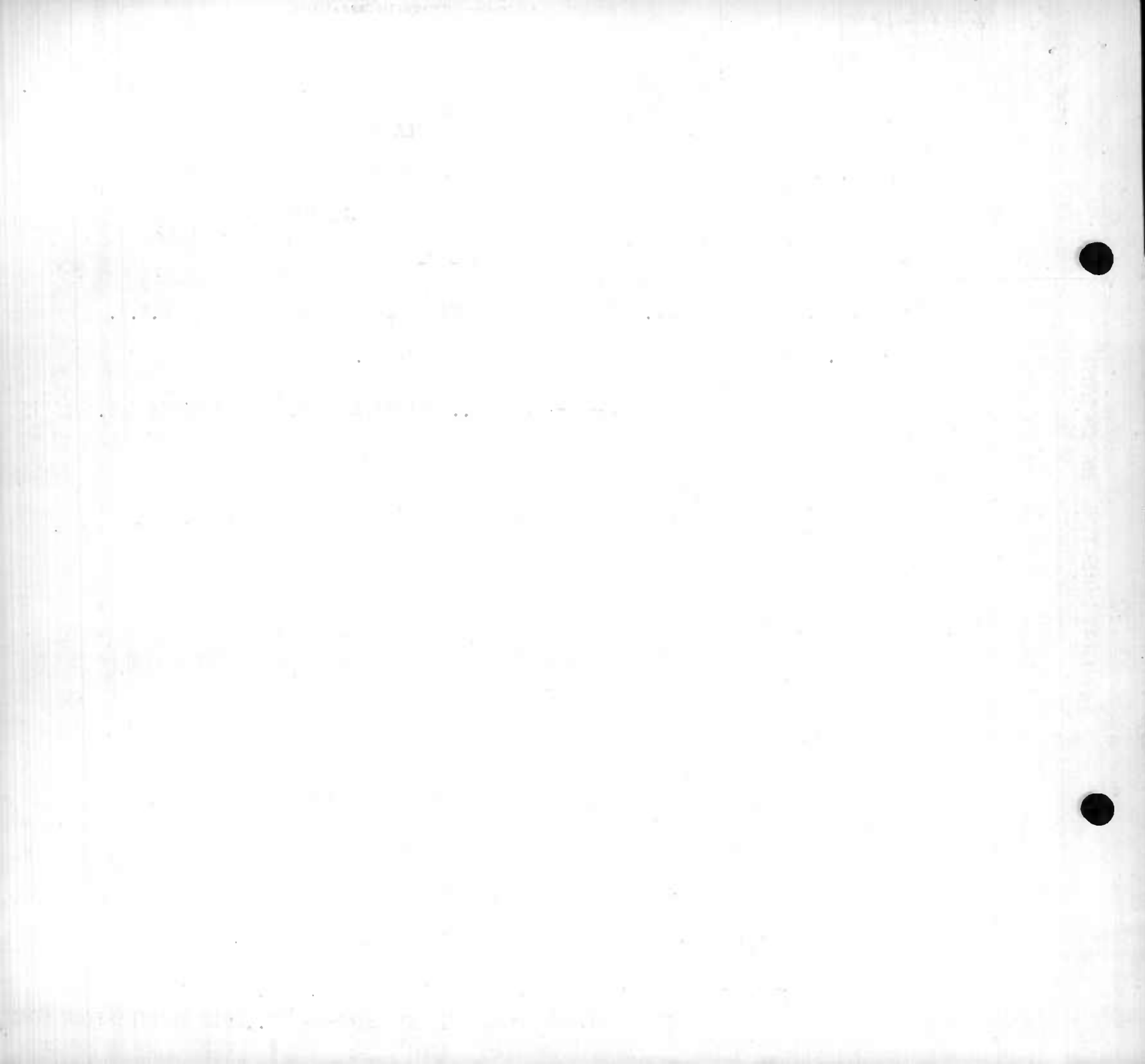
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>69 6616</u>
BIRTH NO. <u>T-16169-09469</u>		1. NAME OF DECEASED (Type or Print) <u>Lauren Toporoff</u>		
2. DATE AND HOUR OF DEATH <u>6/29/69 12:34 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hosp.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2755</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2247 Rogene Dr. 21209</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/28/69</u>	9. AGE (In years last birthday) <u>1</u> Under 1 Yr. Months: <u>0</u> Days: <u>0</u> Hours: <u>0</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Stuart Toporoff</u>		14. MOTHER'S MAIDEN NAME <u>Ann Sweidel</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>2247 Rogene DR. 21209</u>
18. <u>223.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Mucus Bronchial Plug</u> (B) <u>Cystic Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Lifelong</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Intestinal Obstruction 1 week</u>		
19A. DATE OF OPERATION <u>5/30/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Meconium ileus</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6/22</u> 19 <u>69</u> to <u>6/29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Russell W. Chesney</u>		23B. DATE SIGNED <u>6/29/69</u>		
23C. PHYSICIAN'S NAME (Type) <u>RUSSELL W. CHESNEY M.D.</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>6-30-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Beth David</u>
24D. LOCATION (City, town, or county) (State) <u>Elmond, New Jersey</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>561 E. 30th St + Bklyn. 6010 RIVERSIDE AVE</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

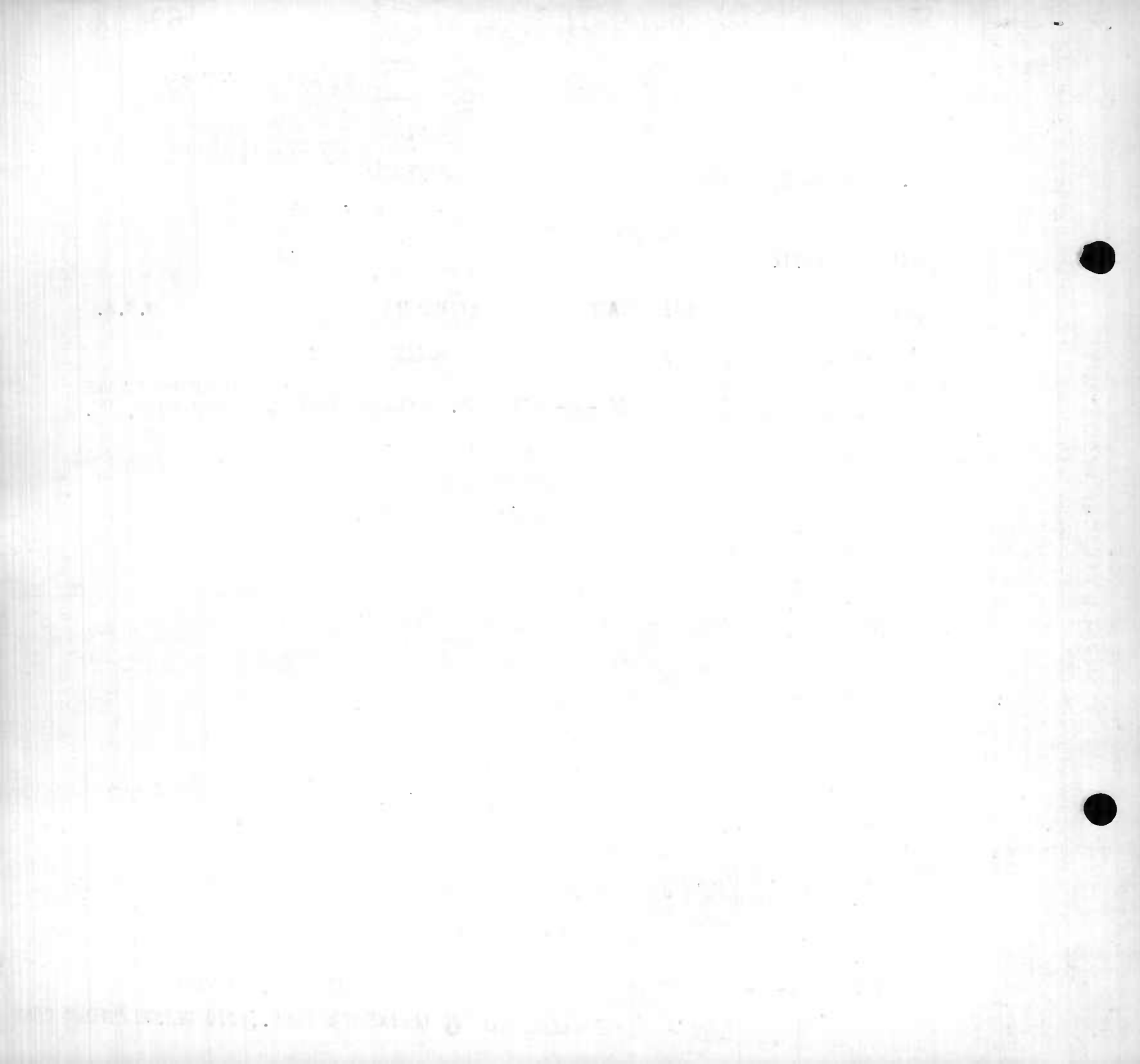
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6617
L-100 BIRTH NO.		69 6617 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ROBERT EARL LEAVEY		2. DATE AND HOUR OF DEATH JUNE 29, 1969 4:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 42		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2719 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5719 JONQUIL AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1905	9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISTRICT SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY BALTO. EVENING SUN		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MORRIS I. LEAVEY		
14. MOTHER'S MAIDEN NAME ANNIE A. SHERMAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 213-03-2915		17. INFORMANT MRS. SYLVIA LEAVEY, 5719 JONQUIL AVE. #21215		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Ruptured aortic aneurysm Myocardial infarction arteriosclerosis Hypertension Constipation Depression		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr 1 1/2 hr 20 yrs 25 yrs 1 wk 1 yr		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		20A. AUTOPSY? (Yes or No) NO		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) AT HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) AT HOME		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) June 23, 1969		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR? AT HOME		22. I certify that (I) (this hospital) attended the deceased from April 29, 1969 to June 23, 1969 , that (I) (we) last saw the deceased alive on June 23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Jonas Cohen		23B. DATE SIGNED June 30, 1969		23C. PHYSICIAN'S NAME (Type) JONAS COHEN
23D. ADDRESS 6702 PARK HEIGHTS AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 6-20-69		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR John E. Taylor, R.D.		
25C. FUNERAL DIRECTOR SO LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

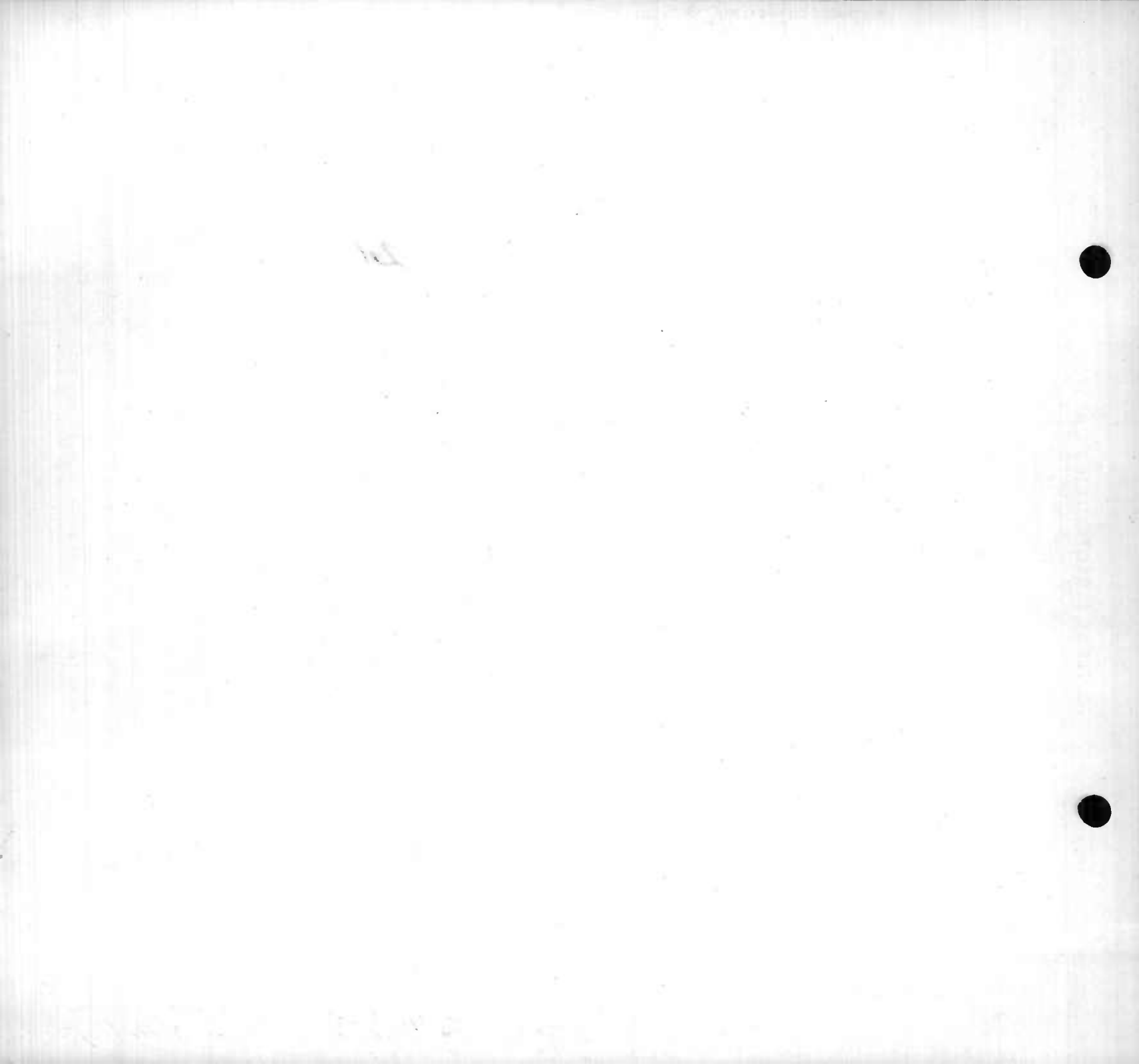
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6618
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH SISKIND		5:45 AM 6-29-69	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MT. SINAI NURSING HOME			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN TAKOMA PARK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
70			E. STREET AND NUMBER 701 DOMER AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 84	if Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROKER		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WOLF SISKIND			14. MOTHER'S MAIDEN NAME BELLE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-32-0557	17. INFORMANT MRS. CECILIA SISKIND, 701 DOMER AVENUE, TAKOMA PARK, MD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Prob. myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gen. AS., CVA, old (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from April 1969 to present, that (I) (we) last saw the deceased alive on 6-13-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Daniel Dzial MD			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-29-69
23C. PHYSICIAN'S NAME (Type) DANIEL DZIAL, MD			23D. ADDRESS 3600 LOCKHART DR 2107		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-30-69	24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Talley, MD.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

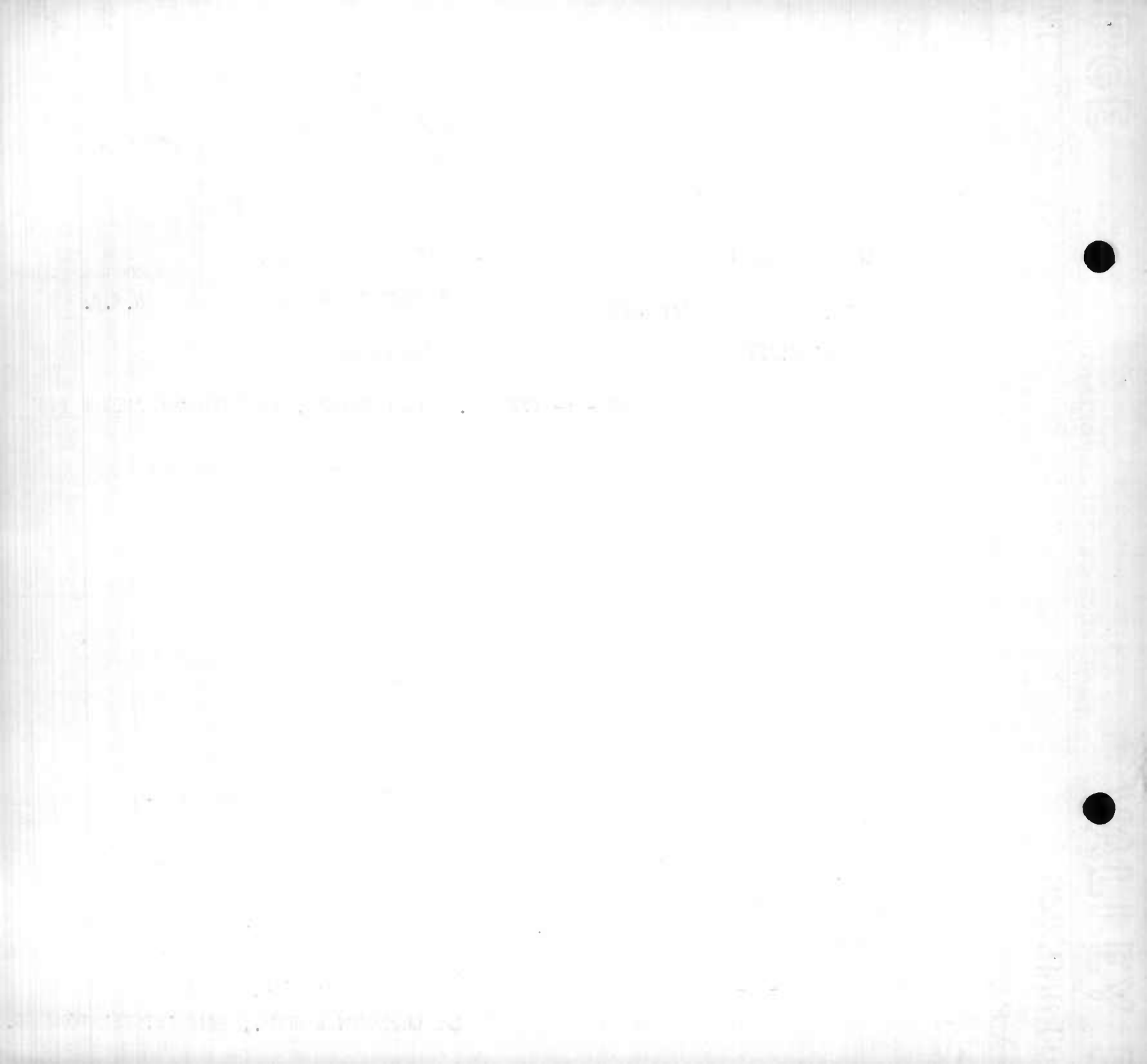
BIRTH NO. 69 6619				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-7721 69 6619	
1. NAME OF DECEASED (Type or Print) WILLIAMS. JOHN R.				2. DATE AND HOUR OF DEATH 6-29-69 4³⁰ P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1605			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL of MD				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2401 EDMONSON AVE.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 6-29-21	9. AGE (In years lost birthday) 48	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Robert Williams			
14. MOTHER'S MAIDEN NAME Elenora Kelly				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII			
16. SOCIAL SECURITY NO.				17. INFORMANT Family			
18. ADDRESS same				19. CAUSE OF DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 431.9 I INTRACEREBRAL HEMORRHAGE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intracerebral hemorrhage			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-29-69 4³⁰ P M. to 6-29-69 4³⁰ P M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sy Huh				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) SOUNG YOON HUH MD				23D. ADDRESS LUTHERAN HOSPITAL of MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. J. Baker, M.D.		25C. FUNERAL DIRECTOR 1011-13		ADDRESS 5011 Van Fleet Home - N. Arlington Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

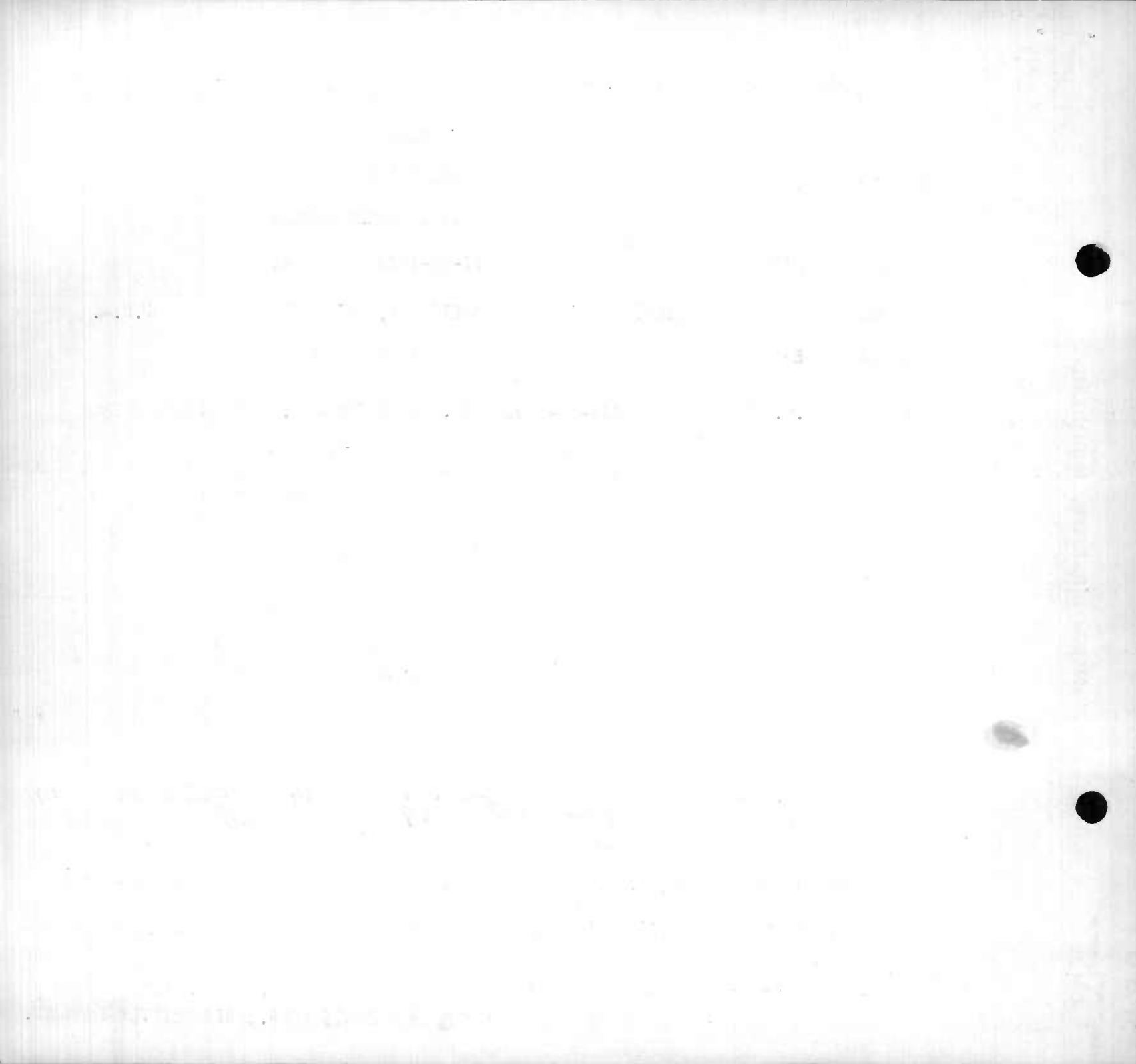
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO.	69 6620
S-200 69 6620 CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print) Jennie Sacks										2. DATE AND HOUR OF DEATH 6.26.69 1:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2788	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH 2. 11. 07 9. AGE (In years last birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE										10B. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) XXXXXXXXXX RUSSIA										12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME HYMAN GREENBLATT										14. MOTHER'S MAIDEN NAME RACHAEL LENER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO										16. SOCIAL SECURITY NO. 215-05-0877	
17. INFORMANT MR. JOSEPH SACKS										ADDRESS 5035 DENMORE AVENUE #15	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ABDOMINAL CARCINOMATOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Ca Transverse Colon										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 6-10-69										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED G.I. bleeding	
20A. AUTOPSY? (Yes or No) no										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from 5.29.69 19 to 6.26.69 19 that (I) (we) last saw the deceased alive on 6.20.69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J.R. Chloca interne										23B. DATE SIGNED 6.26.69	
23C. PHYSICIAN'S NAME (Type) J. R. Chloca, interne										23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL										24B. DATE 6-27-69	
24C. NAME OF CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL										24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969										25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR COL DEVINSON & BROS.										ADDRESS 6010 REISTERSTOWN RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

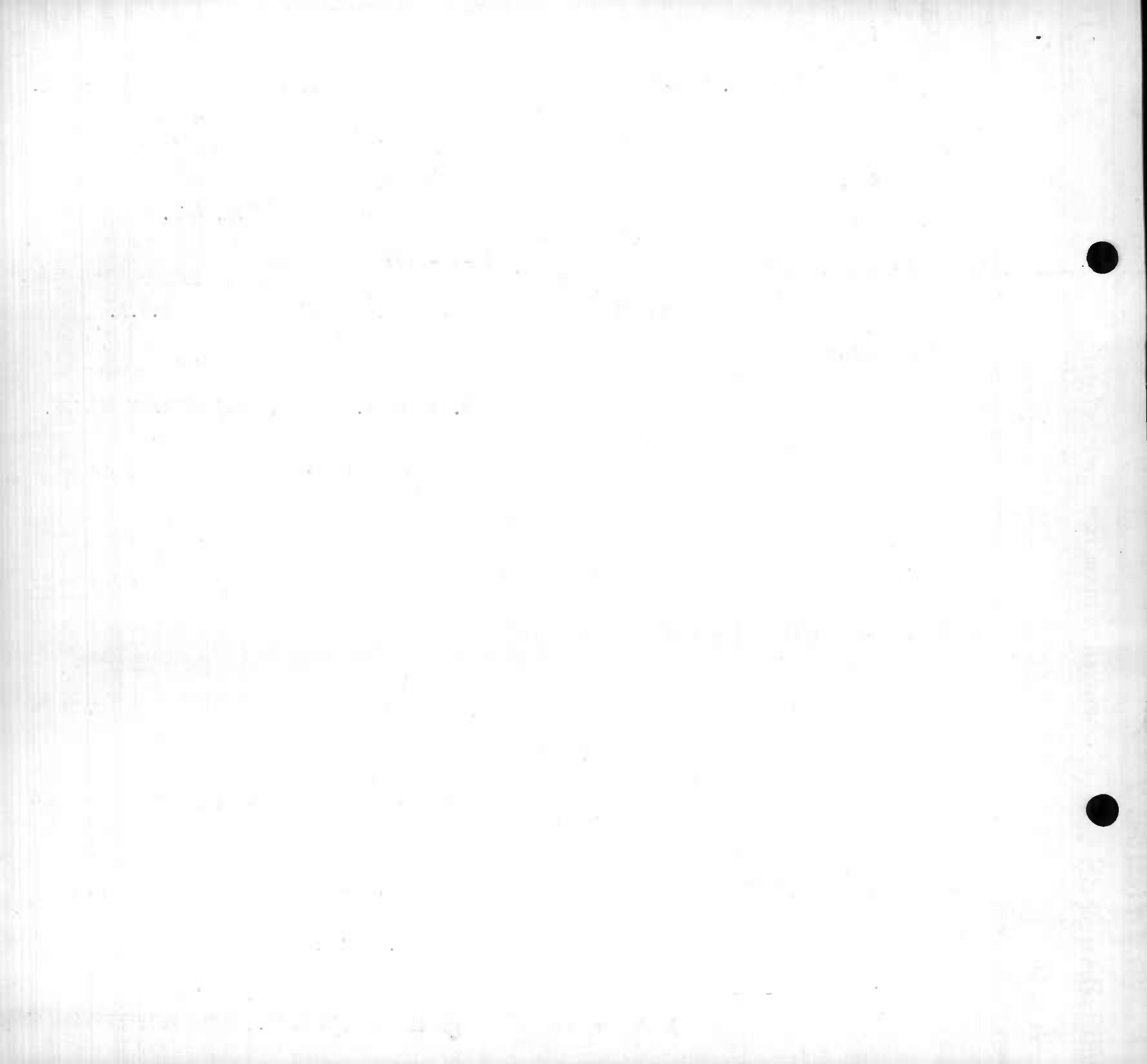
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6621	
<div style="display: flex; justify-content: space-between;"> P-612 69 6621 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) LEONARD PREBESH		2. DATE AND HOUR OF DEATH June 27, 1969 1:08 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4921 NELSON AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-1925	9. AGE (In years last birthday) 43
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY ELECTRONICS		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME SAMUEL PREBESH		14. MOTHER'S MAIDEN NAME ANNA LEVIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		16. SOCIAL SECURITY NO. 214-20-9095		17. INFORMANT MRS. RHODA PREBESH, 4921 NELSON AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 189.0 I Carcinoma of Kidney (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Metastatic to liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. nr		CAUSE OF DEATH Carcinoma of Kidney (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Metastatic to liver (B) DUE TO, OR AS A CONSEQUENCE OF: nr (C) nr		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). nr					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1 19 64 to June 27 19 69 , that (I) (we) last saw the deceased alive on June 27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Levin		23B. DATE SIGNED 6/27/69		23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN	
23D. ADDRESS M. 6101 PARK HIGTS AVE. BALTO - 15 MD		23E. NAME OF REGISTRAR Paul S. Faber, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 6-29-69		24C. NAME of CEMETERY or CREMATORY BETH EL CEMETERY	
24D. LOCATION (City, town, or county) (State) PARAMUS, NEW JERSEY		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969			
25B. NAME OF REGISTRAR Paul S. Faber, M.D.		25C. FUNERAL DIRECTOR SOB LEVINSON & BROS., 6010 REISTERSTOWN RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6622
5-536		69 6622		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MORRIS S. SNYDER		JUNE 27, 1969 5:20 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38		A. STATE MARYLAND		
		C. CITY OR TOWN BALTIMORE		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 5859 WESTERN RUN DRIVE, APT. B		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1899	9. AGE (In years lost birthday) 69
10B. KIND OF BUSINESS OR INDUSTRY SALES RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAMUEL SNYDER		14. MOTHER'S MAIDEN NAME ROSE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ADELE I. SNYDER, 5859 WESTERN RUN DR.
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) Anterior Myocardial Infarction (C) Coronary Insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 14 years 18 years
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 2/26 1946 to 6/27 1969, that (I) (we) last saw the deceased alive on 4/5/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE ISRAEL ZINBERG		23B. DATE SIGNED 6/28/69		23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG
23D. ADDRESS 4000 W. NORTHERN PARKWAY		23E. FUNERAL DIRECTOR ADDRESS SQL REINSON & BROS., 6010 REISTERSTOWN ROAD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-29-69	24C. NAME OF CEMETERY OR CREMATORY MIKRO KODESH BETH ISRAEL	24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6623
F-450		69 6623		CERTIFICATE OF DEATH	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
HARRY FLOAM			JUNE 29, 1969 12:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BELVEDERE, HOUSE IN THE PINES 90			A. STATE MARYLAND B. COUNTY 2831		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 4211 FORDS LANE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-1888	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETAIL		MERCHANT		RUSSIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
BEREL FLOAM			SARAH ?/		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-32-6999A		MRS. KATHERINE FLOAM, 4211 FORDS LANE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH Heart Myocardial Infarction Sec. 1000		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 19 69 to June 29 19 69, that (I) (we) last saw the deceased alive on June 25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard Kotz M.D.				23B. DATE SIGNED 6/30/69	
23C. PHYSICIAN'S NAME (Type) LEONARD KOTZ				23D. ADDRESS ELEVEN SLADE AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		6-30-69		AGUDAS ACHIM ANSHE SFARD	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
ROSEDALE, MARYLAND		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 1 1969		[Signature]		SOL LEVINSON	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6624
BIRTH NO. 1. NAME OF DECEASED (Type or Print) GOODMAN, Hilda		2. DATE AND HOUR OF DEATH 6-27-69 8:30 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LEVINDALE HEBREW HOME & INFIRMARY		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6204 PEARCE AVENUE #21215		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXX	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		9. AGE (In years last birthday) XXIX 76
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME BENJAMIN APPLESTINE		14. MOTHER'S MAIDEN NAME XXX ANNA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-20-5985		17. INFORMANT MRS. BERTHA SWOGELL, 6204 PEARCE AVE. #15 ADDRESS
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Collagen Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____ </div> <div style="width: 10%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk years </div> </div>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4-6-1965</u> to <u>6-27-1969</u>, that <u>we</u> last saw the deceased alive on <u>6-27-69</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ardaiz MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-27-69
23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ		23D. ADDRESS 7 Oberlin Court Towson, Md. 21204		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-29-69		24C. NAME OF CEMETERY or CREMATORY WORKMEN CIRCLE
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. 1969 25B. NAME OF REGISTRAR 9-8-9-69, M.D.		
25C. FUNERAL DIRECTOR 88 LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
G-432		69 6625		69 6625	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
GILADIC, MINNIE M.		6/30/1969 6:10 P.M.		Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md.	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX		6. RACE	
A. STATE Maryland		Female		White	
B. COUNTY		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Baltimore		2-8-99		70	
D. INSIDE CITY LIMITS?		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Housewife		Home	
E. STREET AND NUMBER		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
109 S. Highland Ave. Baltimore, Md. 21224		Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Harry Knorr		Catherine		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
4940 Eastern Ave. Address		Cardiorespiratory Arrest		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
BCH Records: Baltimore, Maryland 21224		Mycardial Infarction		(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)	
		Acute Pulmonary Edema		ANTECEDENT CAUSES	
		Diabetes Mellitus		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/29/1969 1969 to 6/30 1969, that (I) (we) lost saw the deceased alive on 6/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Francisco Tejada M.D.		6-30-69		FRANCISCO TEJADA M.D.	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify)		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial 111 July 3, 1969		Mount Carmel Cem		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 1 1969		John S. Tebb, M.D.		Joseph J. Gorman 263 S. Conkling	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6626	
CERTIFICATE OF DEATH					
BIRTH NO. 69 6626					
1. NAME OF DECEASED (Type or Print) <i>A. Louis Kralick</i>			2. DATE AND HOUR OF DEATH <i>7/1/69</i> <i>3</i> <i>A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 MIDTOWN HOME, INC. 808 St Paul St Baltimore, Md</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>702</i>		
			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>824 N. GLOVER ST.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/3/84</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BAKER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>BAKERY</i>		11. BIRTHPLACE (State or foreign country) <i>WISCONSIN</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>LOUIS KRALICK</i>			14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217 07 0972</i>		17. INFORMANT <i>Dr. Arthur W. Kralick - 905 N. Trigg Ave Baltimore, Md. 21205</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardio Respiratory Failure</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD Paraplegia (emphysema?) (B) DUE TO, OR AS A CONSEQUENCE OF: Urinary tract Infection (C)</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 23</i> 19 <i>69</i> to <i>July 1</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>July 1</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE <i>William Appleford</i>				23B. DATE SIGNED <i>7/1/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>William Appleford</i>				23D. ADDRESS <i>6615 New Richmond Rd</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>		24B. DATE <i>7-1-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>GREENMOUNT CREMATORY</i>	
				24D. LOCATION (City, town, or county) (State) <i>BALTO., Md.</i>	
25A. DATE RECEIVED BY HEALTH DEPT <i>JULY 1 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Staben, M.D.</i>		25C. FUNERAL DIRECTOR <i>Appleford - 2331 Jefferson St.</i>	

1. The first of these is the
the second is the
the third is the

the fourth is the
the fifth is the
the sixth is the
the seventh is the
the eighth is the
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the tenth is the

Common to all of these is the
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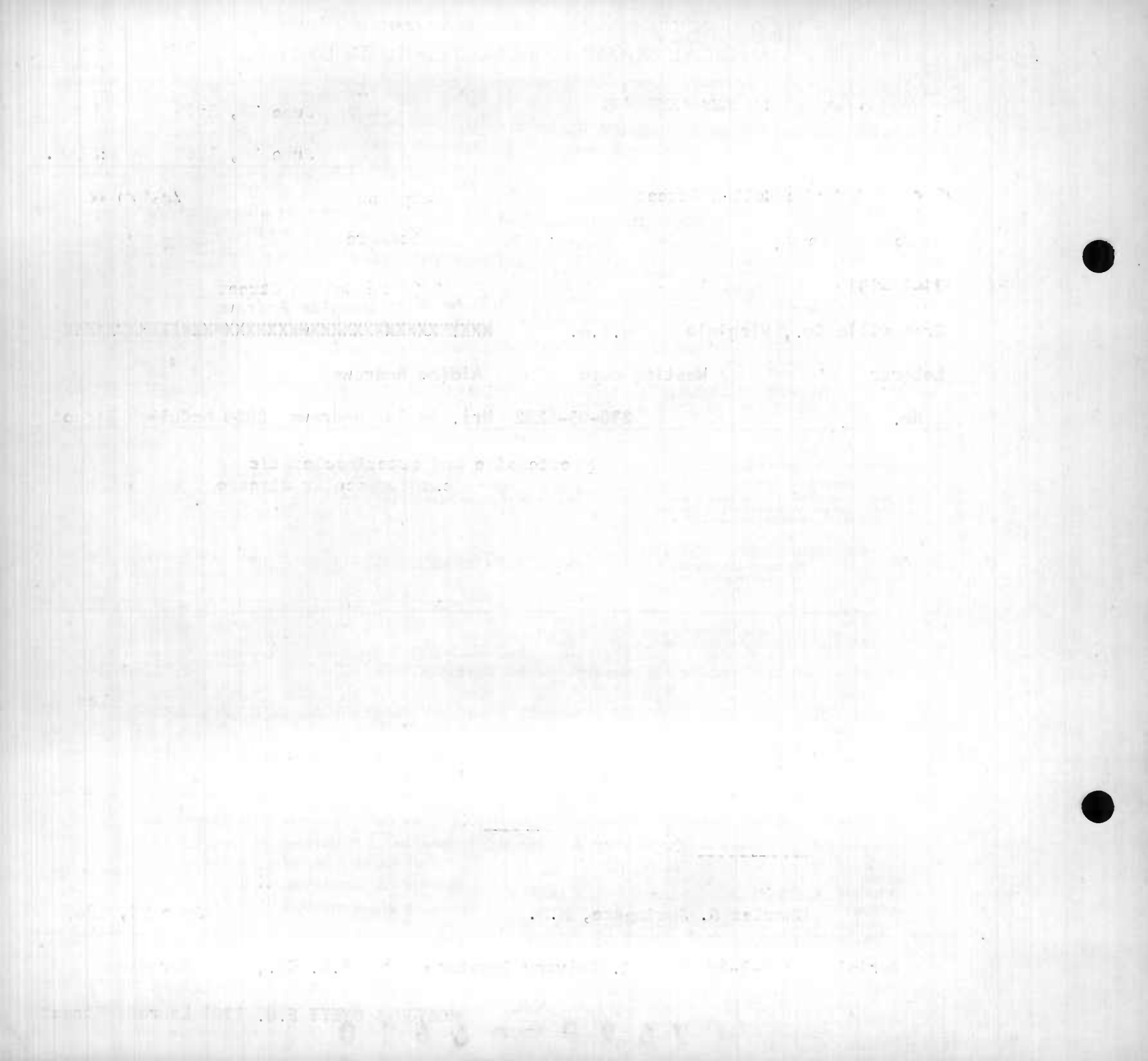
1
A-53669 6627 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6627

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CHARLES ANDREWS (Charlie)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 28, 1969		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2029 Mc Culloh Street		3. DATE PRONOUNCED DEAD Month Day Year June 28, 1969		Hour M. 6:31 P.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1403				
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 11-17-1919		10. AGE (In years last birthday) 49	E. STREET AND NUMBER 2029 Mc Culloh Street	
11. BIRTHPLACE (State or foreign country) Greenville Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Douglas Andrews XX
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Westinghouse		15. MOTHER'S MAIDEN NAME Aldine Andrews
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. 230-03-6292		18. INFORMANT ADDRESS Mrs. Beulah Andrews 2029 McCulloh Street
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 29, 1969 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-69	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

BRODIE MITCHELL

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

June 29, 1969

10:20 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTO. CITY HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 29, 1969

10:20 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5-8-1902

10. AGE (In years
last birthday)

67

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

405 New Pittsburg Avenue

11. BIRTHPLACE (State or foreign country)

Arulander, North Carolina

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Moses Mitchell

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

Beth-Steel

15. MOTHER'S MAIDEN NAME

Unk.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or doles of service)

No.

17. SOCIAL
SECURITY NO.

213-07-3241

18. INFORMANT

Mr. William J. Mitchell

ADDRESS

405 New Pittsburg Ave

19. 185X I

CAUSE OF DEATH

Carcinoma of Prostate

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/20/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-3-69

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

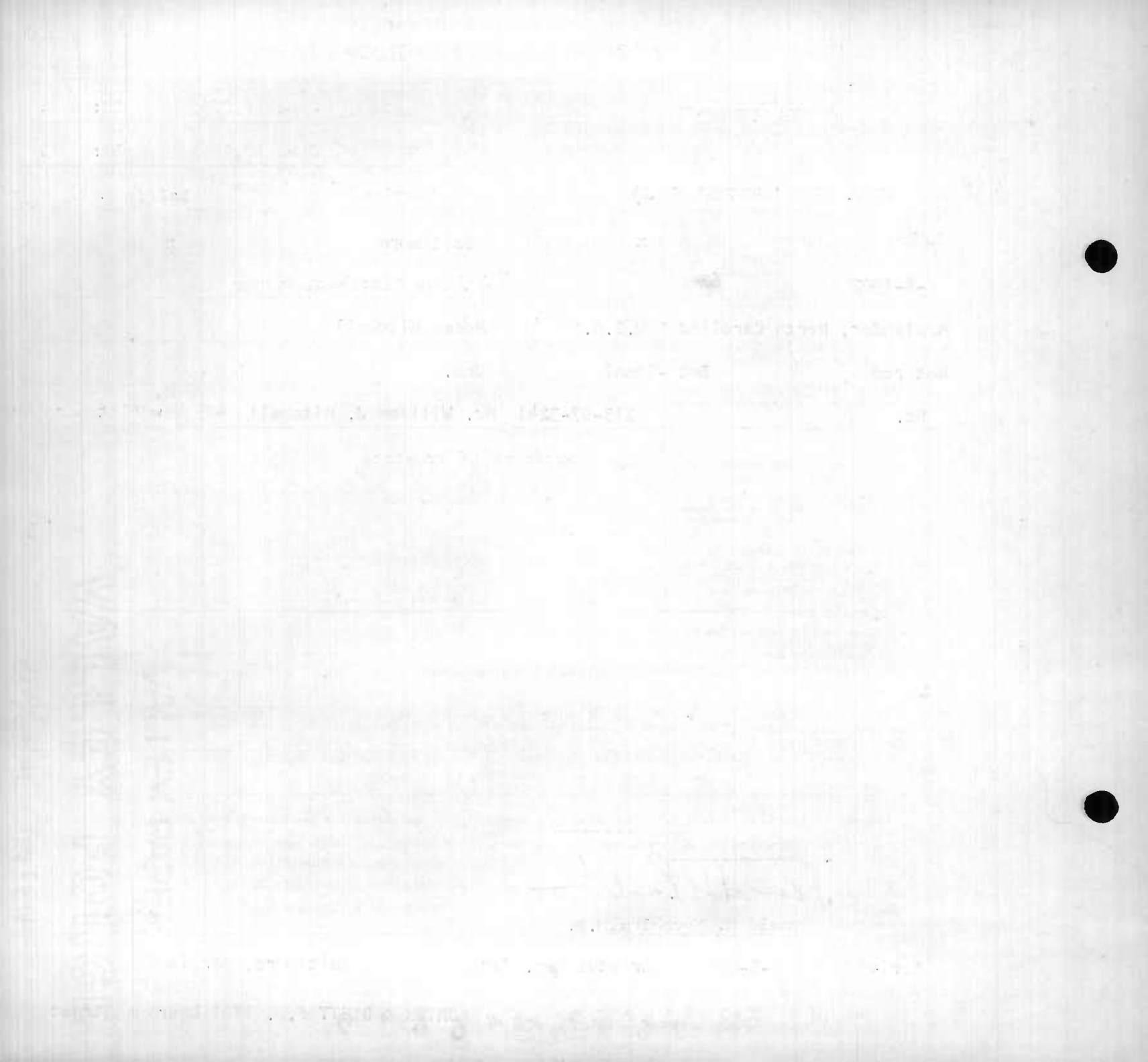
25C. FUNERAL DIRECTOR

ADDRESS

JUL 1 1969

Robert E. Taylor, M.D.

MORTON & DYETT F.H. 1701 Laurens Street



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
69 6629 CERTIFICATE OF DEATH					REG. NO. 69 6629				
1. NAME OF DECEASED (Type or Print) <i>Isabelle Vaughn (Vaughan)</i>					2. DATE AND HOUR OF DEATH <i>June 27, 1969 7⁰⁵ P M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Belts City</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Harbor View Nursing Home</i> <i>1213 Light St</i>					C. CITY OR TOWN <i>Belts</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <i>210 S. Dallas Court</i>				
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-10-02</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Colombia S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Adam Portee</i>					14. MOTHER'S MAIDEN NAME <i>Portee, Della</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>213-09-8493</i>		17. INFORMANT <i>Mr. Ernest Good</i>		ADDRESS <i>1424 Fulton Ave</i>		
18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Arrest</i> <i>Tachycardia</i> <i>Art. Sel. C-V Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Art. Disease</i> (C) <i>Cerebral Art. Sel. Sclerosis</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hr</i> <i>15 yr.</i> <i>2 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>6-3-1969</i> to <i>6-27-1969</i> , that (we) lost saw the deceased alive on <i>6-27-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Kenneth Krulevitz MD</i>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>7-1-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kenneth Krulevitz, M. D.</i>					23D. ADDRESS <i>7538 Holabird Avenue #21222</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>7/1/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>A.A. Co, Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Hahn, M.D.</i>			25C. FUNERAL DIRECTOR <i>W. H. H. H. H. H.</i>			ADDRESS <i>1701 Lourens</i>	

101 11
101 11
101 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

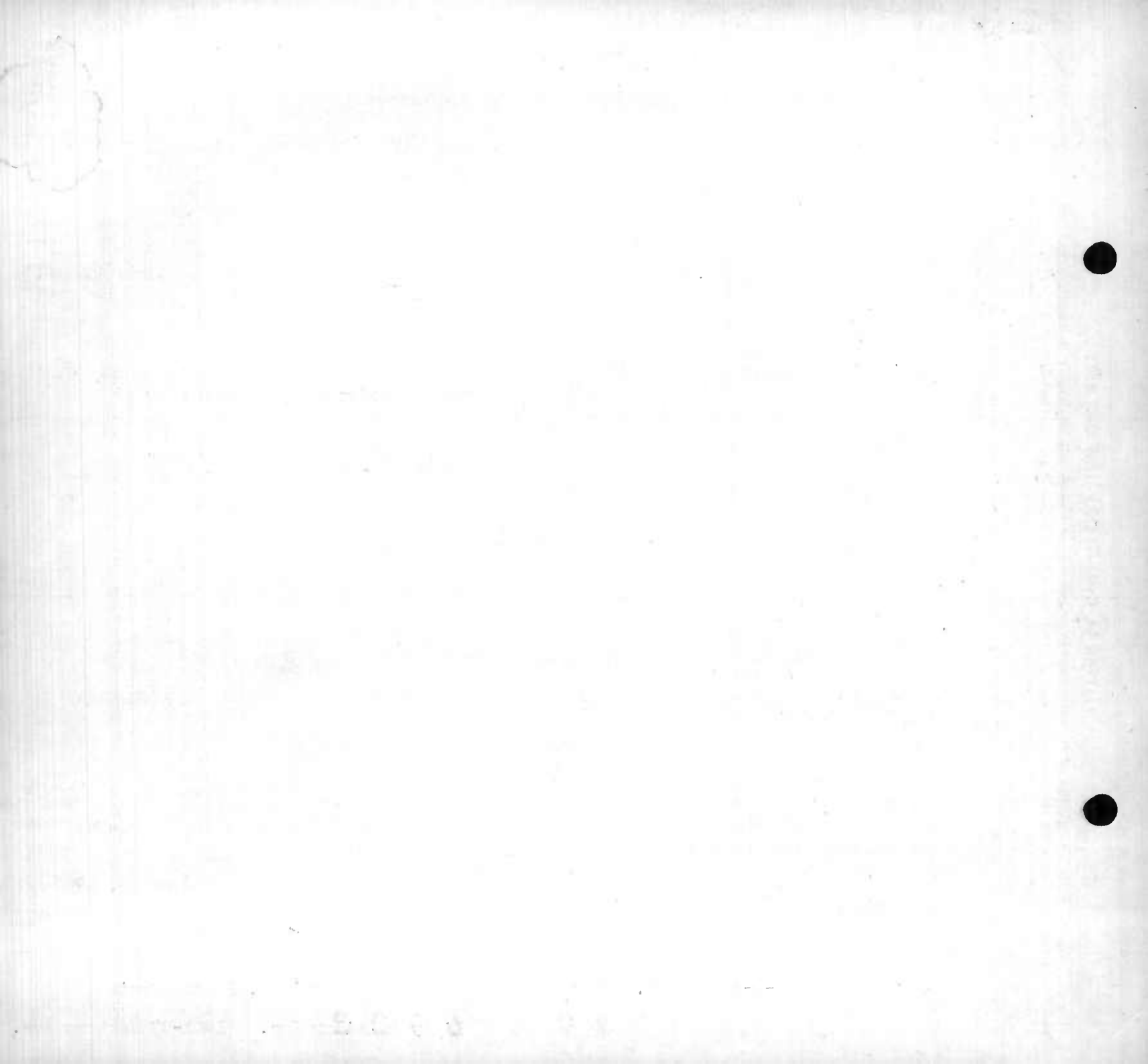
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6630	
BIRTH NO. 69 6630				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BEATRICE WILSON			2. DATE AND HOUR OF DEATH 6-27-69 8:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL OF MARYLAND			A. STATE Maryland B. COUNTY 1703		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 851 George St.		
5. SEX FEMALE	6. RACE COLOR	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-10	9. AGE (in years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Henson			14. MOTHER'S MAIDEN NAME Rosa Henson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Annette Elkins		
			ADDRESS 839 N. Fremont Ave		
18. 73301 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Probably Infarction & Hemorrhage Hypertension			CAUSE OF DEATH (A) IMMEDIATE CAUSE - Cerebral Vascular Disease DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? -		
22. I certify that (I) (this hospital) attended the deceased from 6-9-69 19 69 to 6-27 19 69 that (I) (we) last saw the deceased alive on 6-27 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Srikumpol M.D.			23B. DATE SIGNED 6-27-69		
23C. PHYSICIAN'S NAME (Type) ANANTA SRIKUMPOL			23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-2-69	24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969	25B. NAME OF REGISTRAR Robert E. J. [unclear]	25C. FUNERAL DIRECTOR Martha E. Dyer F.H.	ADDRESS 1701 Laurens St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

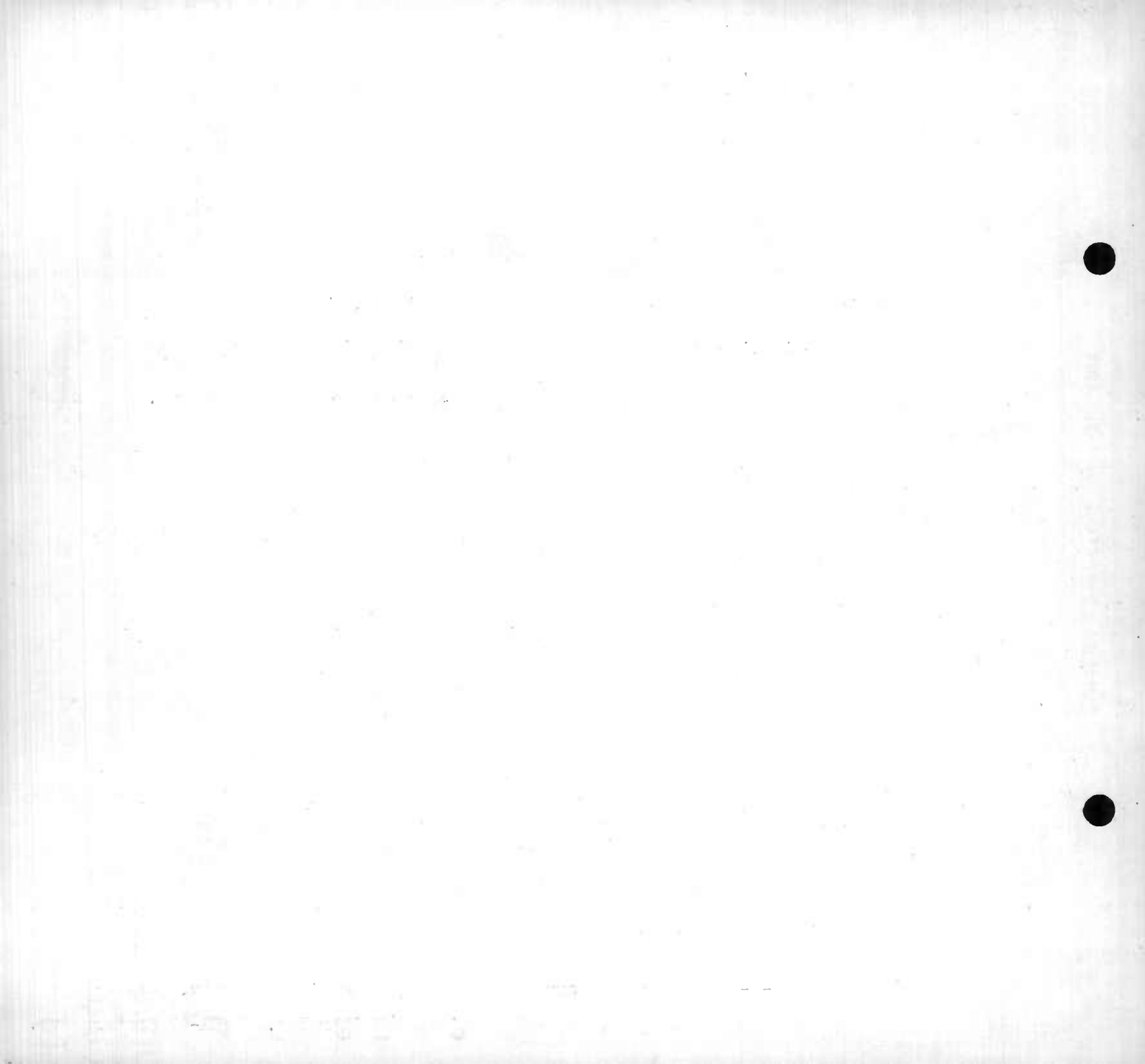
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6631	T
BIRTH NO. 69-11289		CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Hartzel</u>		BABY BOY HARTZEL		2. DATE AND HOUR OF DEATH <u>6/29/69</u> <u>13:23</u> <u>A</u> M.		
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2534</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home + Hospital</u> <u>35</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore 21225</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>504 Arsan Avenue</u>		
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/69</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Raymond E. Hartzel</u>		14. MOTHER'S MAIDEN NAME <u>MARY LILLER</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Raymond Hartzel 504 Arsan Avenue</u>		
18. <u>770.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>abruptio placentae</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Jane Plethra</u>		23B. DATE SIGNED <u>June 29, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>Church Home & Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-2-1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Johns</u>		24D. LOCATION (City, town, or county) (State) <u>Barnsville, Pennsylvania</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Gill & Zeiler Inc. 1901-07 Eastern Ave.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	REG. NO.	69 6632
BIRTH NO.		1. NAME OF DECEASED (Type or Print) AGNES H. LEAGUE		2. DATE AND HOUR OF DEATH 6-30-69 12:34 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto C.		52-90		
FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW CC. 1213 Light St.		C. CITY OR TOWN Balto City		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
90 BALTO MD		E. STREET AND NUMBER Linthicum Hgts				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 5, 1901	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Louis Wieprecht		14. MOTHER'S MAIDEN NAME Vicoria Puschnovsky				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-4057B		17. INFORMANT ADDRESS Edmund League 404 Laura Ave. 21090		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 599.04 + 250.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cerebral Palsy infection DUE TO, OR AS A CONSEQUENCE OF:			2 days	
(C) _____						
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Diabetes Mellitus	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (H) (this hospital) attended the deceased from 5/28 19 68 to 30 June 19 69 , that (H) (we) last saw the deceased alive on 30 June 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.						
23A. SIGNATURE A. C. AREVIZABOS, MD				23B. DATE SIGNED 1 July 69		
23C. PHYSICIAN'S NAME (Type) A. C. AREVIZABOS, MD				23D. ADDRESS 1205 St Paul St. Balto 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-1969		24C. NAME OF CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Miller, MD		25C. FUNERAL DIRECTOR ADDRESS Gally & Zeiler Inc. 1901-07 Eastern Ave.		



Release of an approved medical examiner
6/30/69
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6633 CERTIFICATE OF DEATH

REG. NO. 69 6633

BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Mildred M. Malthan</u>		<u>June 30 1969</u> <u>1:25 a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp.</u>		A. STATE <u>Md.</u> B. COUNTY <u>903</u>	
5. SEX <u>F</u>		C. CITY OR TOWN <u>Baltimore</u>	
6. RACE <u>W</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>3629 E. Keader Rd.</u>	
8. DATE OF BIRTH <u>4/25/90</u>		9. AGE (In years last birthday) <u>79</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md.</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Stermer</u>		14. MOTHER'S MAIDEN NAME <u>Sophronia Collett</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-8685</u>	
17. INFORMANT <u>Edward C. Stermer</u>		ADDRESS <u>211 GATESWOOD RD TIMONIAN Md.</u>	
18. <u>4-37-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Branchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebrovascular arteriosclerosis</u> (B) _____ (C) _____ <u>D.H.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>6/30/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Yes</u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 12 1969</u> to <u>June 30 1969</u> that (I) (we) last saw the deceased alive on <u>June 30 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Dr. Charles R. Goshen</u>		23B. DATE SIGNED <u>6/30/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Charles R. Goshen</u>		23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/2/69</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>John E. Taber, Md.</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>	

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100 g

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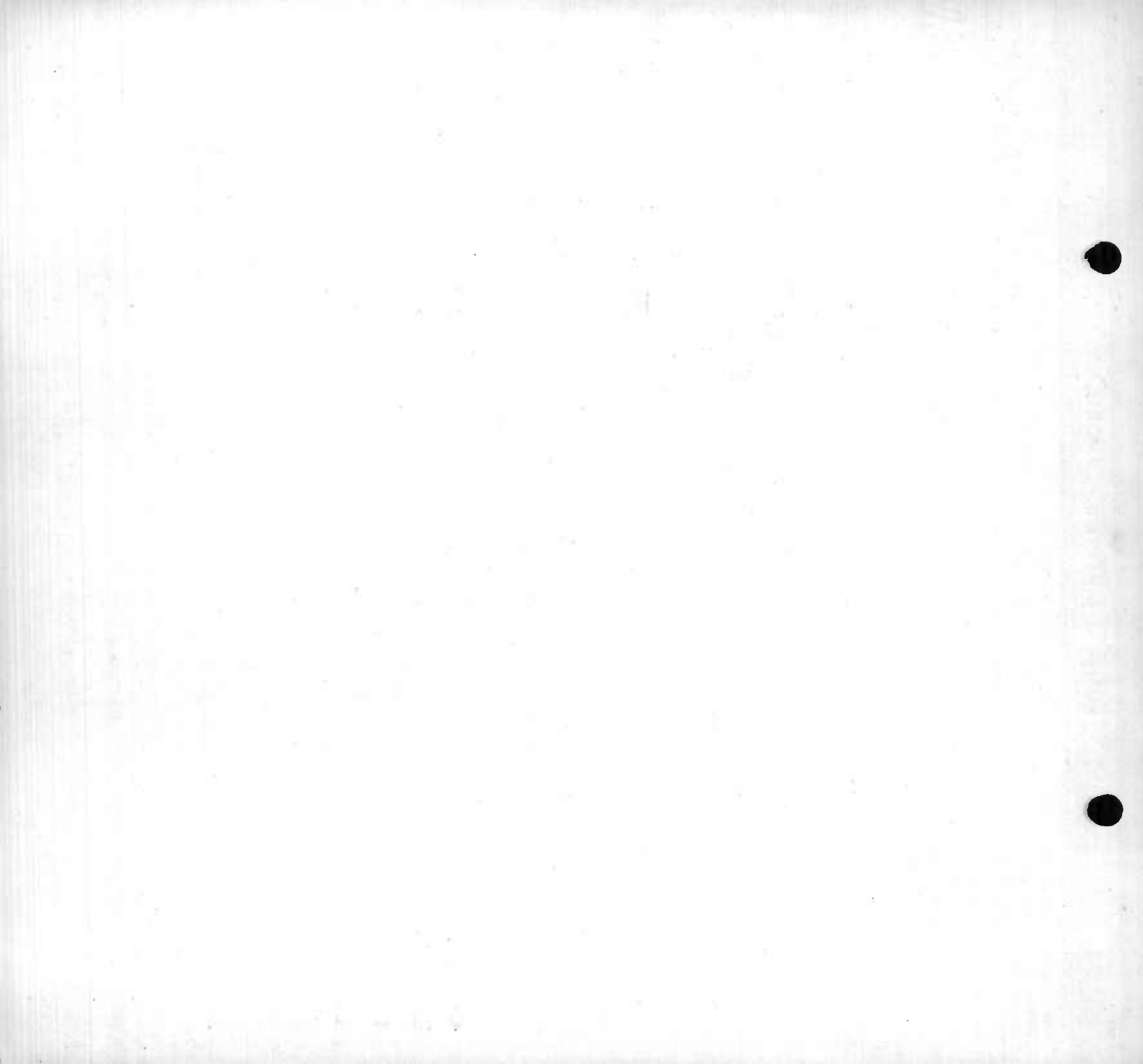
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

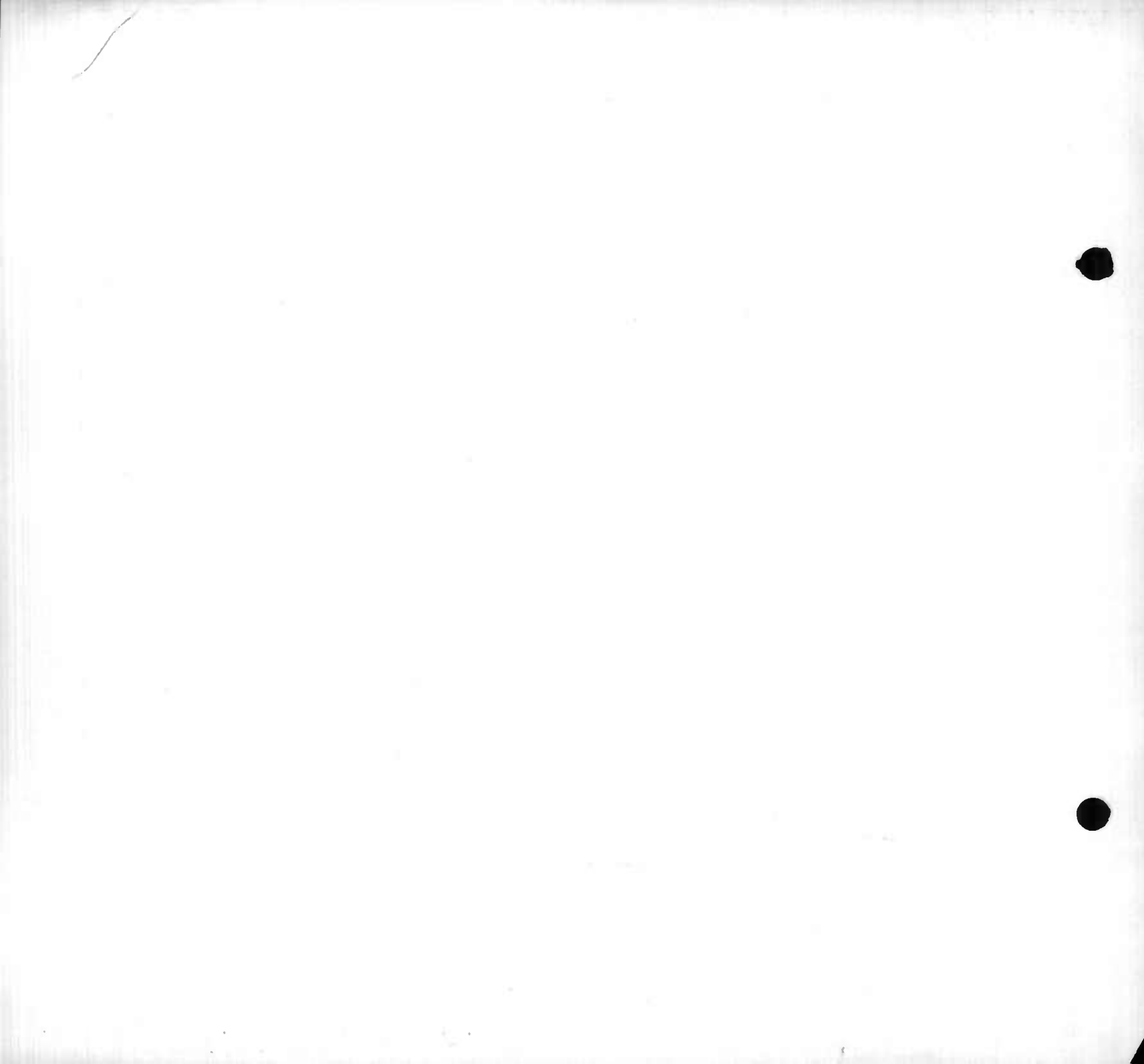
BIRTH NO. 69 6634				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6634			
1. NAME OF DECEASED (Type or Print) MARVEL, MARGUERITE H.				2. DATE AND HOUR OF DEATH JUNE 28 1969 13³⁰ P.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL				A. STATE MARYLAND				B. COUNTY 1307			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 3925 BEECH AVENUE							
5. SEX F		6. RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/89		9. AGE (In years last birthday) 80		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY OWN Home				11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HOGG				14. MOTHER'S MAIDEN NAME MARGARET WILDERMAN							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218280431		17. INFORMANT HOSPITAL CHART				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.3 I DISEASE				CAUSE OF DEATH ARTERIO SCLEROTIC HEART				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 16 19 69 to June 29 19 69 , that <input checked="" type="checkbox"/> (we) lost sight of the deceased alive on June 29 19 69 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.											
23A. SIGNATURE Michael Colvin, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED June 29, 1969			
23C. PHYSICIAN'S NAME (Type) MICHAEL COLVIN, M.D.				23D. ADDRESS GOOD SAMARITAN HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-69		24C. NAME of CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville Balto. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969				25B. NAME OF REGISTRAR James E. Taber, M.D.				25C. FUNERAL DIRECTOR Howe Jenkins & Sons Co.			
				ADDRESS 4905 York Rd. Balto. 21212. Md.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6635				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6635	
1. NAME OF DECEASED (Type or Print) <u>Maudie N. Hooger</u>				2. DATE AND HOUR OF DEATH <u>6-29-69 11 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Md. General Hospital</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Md.</u>		B. COUNTY	
				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4011 Doby Manor Drive</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-93</u>	9. AGE (In years last birthday) <u>75</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Neilson</u>			
14. MOTHER'S MAIDEN NAME <u>Guzanna Wood</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216 18 0233</u>				17. INFORMANT <u>Mrs. Laura Talbot</u>			
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTERIOR MYOCARDIAL INFARCTION (18000000)</u> <u>HEART DISEASE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7/5</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> 19 <u>69</u> to <u>6-29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6-29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Delia Gomez-Dumaran, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-29-1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>Delia Gomez-Dumaran, M.D.</u>				23D. ADDRESS <u>MARYLAND GENERAL HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-2-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot, Jr.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>			
				ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

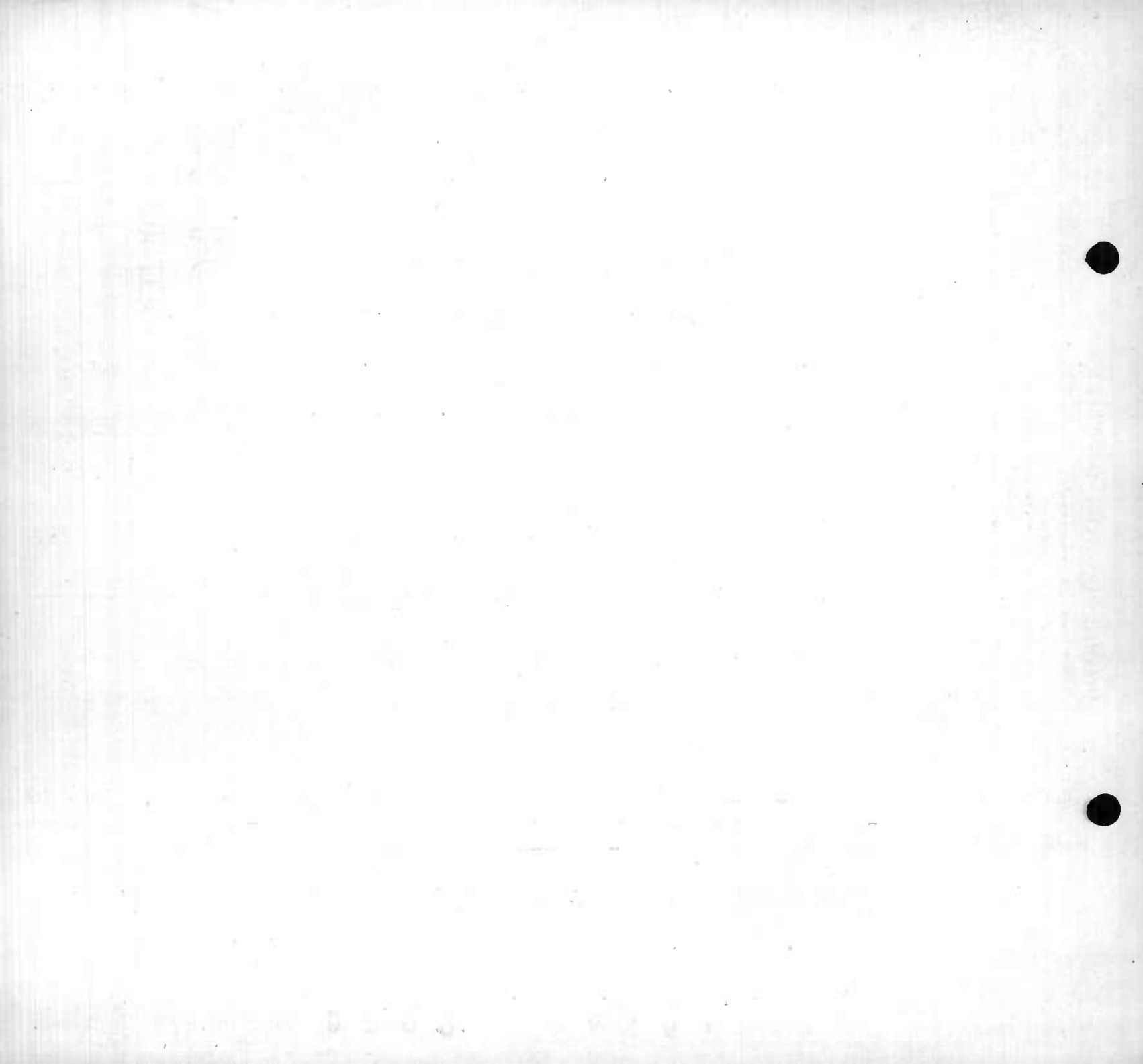
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6636</u>
69 6636				CERTIFICATE OF DEATH
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <u>ADAMS, Myrtle Burton</u>		2. DATE AND HOUR OF DEATH <u>June 30, 1969</u> <u>6:45 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2748</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Female</u> 6. RACE <u>White</u>		E. STREET AND NUMBER <u>5912 Glennor Road</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/24/17</u> 9. AGE (in years last birthday) <u>51</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Burtonsville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A./</u>				
13. FATHER'S NAME <u>Walter T. Burton</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Soper</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> <u>5/3/42 - 1/4/46</u>		16. SOCIAL SECURITY NO. <u>215-26-23-12</u>		17. INFORMANT <u>VA Hospital Records</u> ADDRESS <u>3900 Loch Raven Blvd., Balto., Md. 21218</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>1621 I</u> <u>Bronchogenic carcinoma with</u> <u>widespread metastases</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2 years</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>June 20th</u> 19 <u>69</u> to <u>June 30th</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>June 30th</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Marcia C. Schmidt M.D.</u> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 30, 1969</u>
23C. PHYSICIAN'S NAME (Type) <u>MARCIA C. SCHMIDT, M.D.</u> DEGREE		23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-3-69</u>	24C. NAME of CEMETERY or CREMATORY <u>Balto. Nat'l.</u>	24D. LOCATION (City, town, or county) <u>Baltimore,</u>	(State) <u>Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>	25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto. 21212, Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6637</u>
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		<u>Katherine V. Dugan</u>		<u>June 30, 1969</u> <u>1:30 A.</u> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>651 Dumbarton Ave.</u> <u>00</u>		A. STATE <u>Md.</u>		
		B. COUNTY <u>Baltimore</u>		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		<u>Baltimore</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>651 Dumbarton Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-1899</u>	9. AGE (In years last birthday) <u>69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William J. Greer</u>		14. MOTHER'S MAIDEN NAME <u>Mollie E. Brown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mr. Robert R. Dugan</u>	
			ADDRESS <u>Same</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
		(B) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>10 yrs.</u>
		(C) <u>Cerebrovascular accident with left hemiparesis</u>		<u>14 mo.</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>November 19 64</u> to <u>June 30, 19 69</u> , that (I) (we) last saw the deceased alive on <u>June 19, 19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Lloyd E. Saylor</u>		23B. DATE SIGNED <u>July 1, 1969</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Lloyd E. Saylor</u>		23D. ADDRESS <u>3902 Greenmount Ave.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-2-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. Nat'l.</u>
		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Saylor, D.D.</u>		25C. FUNERAL DIRECTOR <u>H. G. Benkins & Sons Co.</u>
				ADDRESS <u>4905 York Rd. Balto. Md. 21212</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6638	
BIRTH NO. 69 6638		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SADIE R. Ruddy		2. DATE AND HOUR OF DEATH 6-30-69 10³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL		C. CITY OR TOWN Towson D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W.		E. STREET AND NUMBER 304 Stevenson Lane	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-21-17 9. AGE (in years last birthday) 51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
10B. KIND OF BUSINESS OR INDUSTRY Restaurant		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Rinaudo		14. MOTHER'S MAIDEN NAME Cecilia Tumminello	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 216-05-8210	
17. INFORMANT Mrs. Anthony C. Messersmith		ADDRESS 1343 Crofton Rd. - 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatosis months.	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Oct Cell Ca of Lung months.	
		(C) Anemia mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 6-19-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exc. Pyloric C.N.	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/25/69 to 6/30/69 that (I) (we) last saw the deceased alive on 6/30/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. M. Thorn MD		23B. DATE SIGNED 6/30/69	
23C. PHYSICIAN'S NAME (Type) Dr. J. M. Thorn		23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69	
24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Taylor, MD	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Baltimore, Md. 21212	

0119-0-0 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6639

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARTHA MEDLEY

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

6

22

69

2:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home & Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June

22,

1969

2:15 a.m.

5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

604

6. SEX

7. RACE

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

6-16-34

35

220 N. Wolfe St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Virginia

USA

John Paul Carrington

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

no

Elton Muller R.F.W.S. Boston, Va.

19. 345.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Epilepsy

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cirrhosis of the liver

MEDICAL CERTIFICATION

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes (Head)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 22, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 1 1969

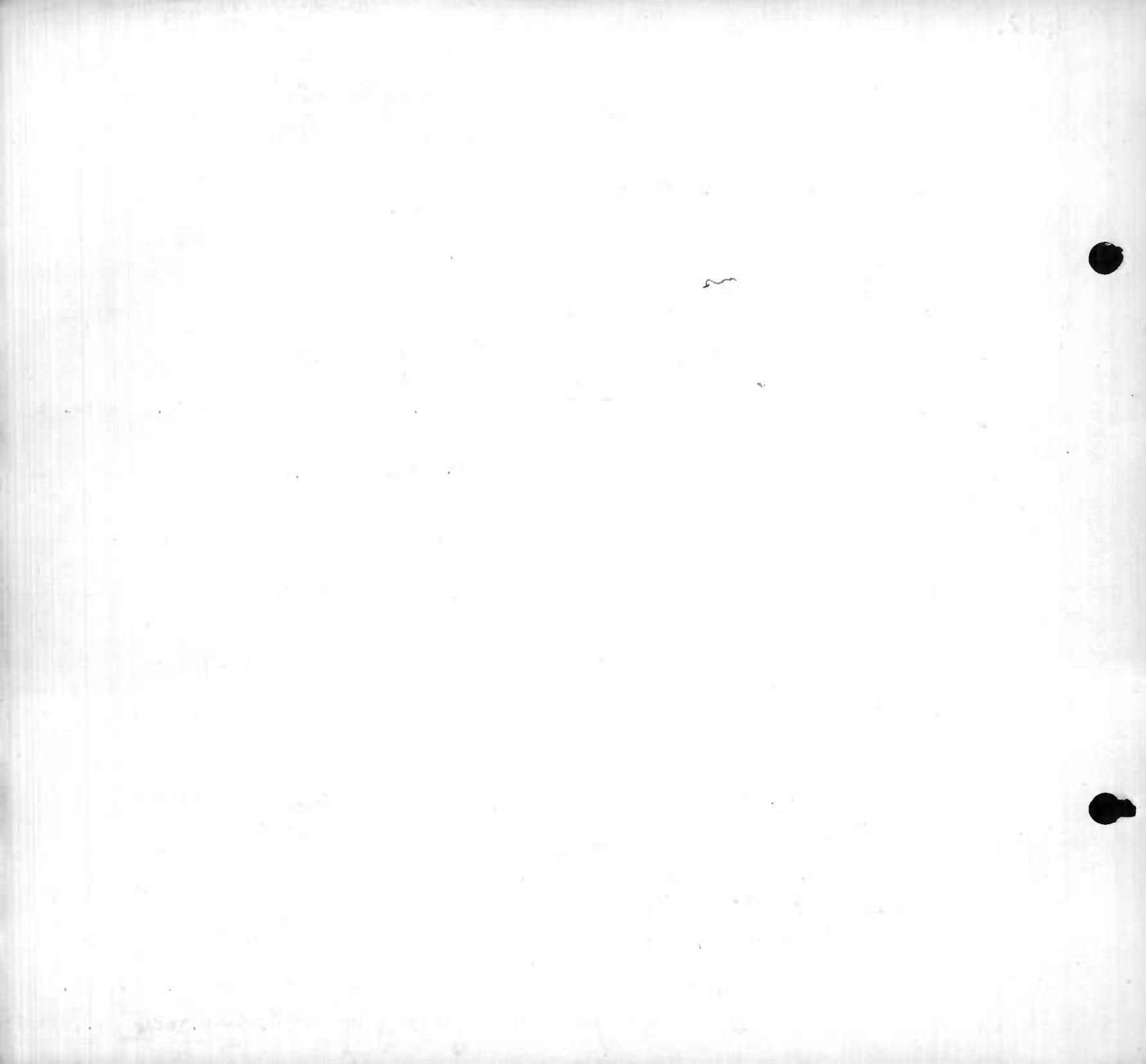
J. E. Taylor, M.D.

Frogan 389 R.I. Gunner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6640	
BIRTH NO.		69 6640		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
PAUL CHARLES TRAVIS			June 29, 1969 7:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		B. COUNTY
			Maryland		
RESIDENCE: 1001 St. Paul Street			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1001 St. Paul Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 16, 1892	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Salesman		Electrical Supplies		Brooklyn, N. Y.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
David Newman			Ida Kalich		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT: Attorney ADDRESS
NO			196-01-5356		John W. Sloan, Fidelity Bldg., Balto. 1
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		Cirrhosis of the liver 5 years			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Oct - 1963 to June 1969 , that (I) (we) last saw the deceased alive on June 29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Louis P. Hamburger Jr.				6/30/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Louis P. Hamburger Jr.		1001 St Paul St Baltimore Md 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		July 2, 69		Druid Ridge	
				24D. LOCATION (City, town, or county) (State)	
				Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 1 1969		Robert E. Tabor, M.D.		STEWART & MOWEN CO. 108 W. North Av., Cityl	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6641 CERTIFICATE OF DEATH				REG. NO. 69 6641	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CATHERINE Lee BROWN		2. DATE AND HOUR OF DEATH June 28, 1969 12¹⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIV. OF Maryland Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 402		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF Maryland Hospital		E. STREET AND NUMBER 746 W. Redwood St.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1899	9. AGE (in years last birthday) 69	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chester town Md.	
13. FATHER'S NAME Lowin Pierce		14. MOTHER'S MAIDEN NAME Eliza Bailey		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Leonard Lee 746 W. Redwood St.	
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) MASSIVE (2) Cerebrovascular occlusion (CVA)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-21-1969 to 6-28-1969 that (I) (we) lost saw the deceased alive on 2⁰⁵ PM 6/28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick N. Pearson, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> House Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 28 June 1969	
23C. PHYSICIAN'S NAME (Type) FREDERICK N. PEARSON, M.D.		23D. ADDRESS 110 W. 39th St. Balto 21210 MD (UNIV. HOSPITAL)			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 7/3/1969	24C. NAME of CEMETERY or CREMATORY St. Lukes Cem.		24D. LOCATION Balta Md.	(City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME of REGISTRAR Joseph E. Fisher, M.D.		25C. FUNERAL DIRECTOR Williams Funeral Home 319 N. Schroeder St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6642	
69 6642 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian Barley</i>		2. DATE AND HOUR OF DEATH <i>June 28 1969</i> 1 55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1604</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>1824 Edmondson Ave</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/30/06</i>	9. AGE (in years last birthday) <i>63</i>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia, Halifax</i>	
13. FATHER'S NAME <i>William Clark</i>			14. MOTHER'S MAIDEN NAME <i>Josie Clock</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Seralstine Powell 1824 Edmondson Ave</i>	
18. <i>450X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Massive pulm. embolism</i> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>		
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-26</i> 19 <i>69</i> to <i>6-28</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>6-28</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>U. Sangrum</i>			23B. DATE SIGNED <i>6-28-69</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <i>U. SANGRUM</i>			23D. ADDRESS <i>B 871</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/1969</i>		24C. NAME OF CEMETERY OR CREMATORY <i>McGowan Cem.</i>	
24D. LOCATION (City, town, or county) <i>Balto. Md.</i>		24E. STATE <i>Md.</i>		24F. COUNTY <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1969</i>		25B. NAME OF REGISTRAR <i>Joseph E. Taylor, R.D.</i>		25C. FUNERAL DIRECTOR <i>Williams Funeral Home 319 N. Belvidere St</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6643

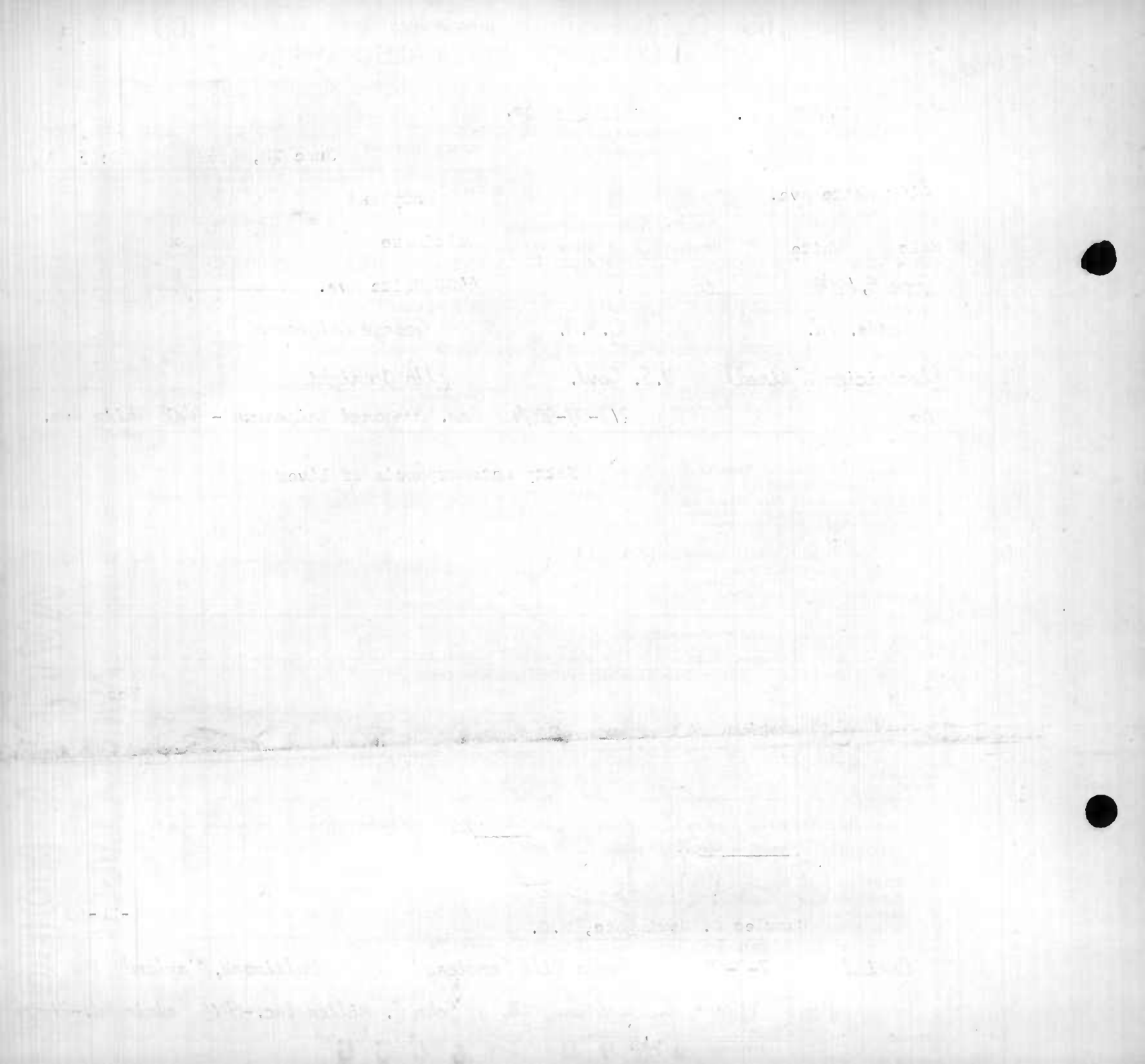
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mildred W. Morgan</u>		2. DATE AND HOUR OF DEATH <u>6:55 AM 6/26/69</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Frederick</u>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University of Maryland Hospital</u>		C. CITY OR TOWN <u>Frederick</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1301 N. Market St.</u>		5. SEX <u>F</u>		6. RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/15/10</u>		9. AGE (in years last birthday) <u>58</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles W. Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Edith E. Crum</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-10-3126</u>		17. INFORMANT <u>John W. Morgan</u> ADDRESS <u>1301 N. Mt. St. The Pt. & her husband Frederick-Md.</u>	
18. I <u>187X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>12/1/68</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca. of bladder</u> 20A. AUTOPSY? (Yes or No) <u>yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Ca. of Bladder Stage D</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10/67-4/69</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>68</u> to <u>6/26</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/26</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael J. [Signature]</u>		23B. DATE SIGNED <u>6/26/69</u>		23C. PHYSICIAN'S NAME (Type) <u>—</u>	
23D. ADDRESS <u>—</u>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. ATTENDING PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-30-1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederick, Maryland 21701</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1969</u>		25B. NAME OF REGISTRAR <u>—</u>	
25C. FUNERAL DIRECTOR <u>Elwood T. Whitmore</u>		25D. ADDRESS <u>Frederick, Md. 21701</u>		25E. NAME OF REGISTRAR <u>—</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) WILLIAM A. BRIGERMAN Sr		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4408 White Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1969 8:05 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 6, 1909		10. AGE (In years lost birthday) 60	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician (Retired)		15. MOTHER'S MAIDEN NAME Ella Upnigh	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-07-9694	
18. INFORMANT Mrs. Margaret Brigerman - 4408 White Ave.		ADDRESS	
19. CAUSE OF DEATH 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-28-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR John C. Miller Inc.		ADDRESS 6415 Belair Rd. - 21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
S-500 69 6645		69 6645		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Maureenah Shami</i>		2. DATE AND HOUR OF DEATH <i>6-25-69 10 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>44 Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5425 Apt C Sarrin Road</i>			
5. SEX <i>♀</i>	6. RACE <i>Indian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-2-68</i>	9. AGE (In years last birthday) <i>#</i>	10. Under 1 Yr. Months Days <i>10 19</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Michigan</i>	
13. FATHER'S NAME <i>Mohammad Shami</i>		14. MOTHER'S MAIDEN NAME <i>Khalida</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Chart</i> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiorespiratory Arrest</i> (B) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Multifactorial Complicated Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>D. H</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 16</i> 19 <i>69</i> to <i>June 25</i> 19 <i>69</i> . that (I) (we) last saw the deceased alive on <i>June 25</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <i>Margaret M. Miller, M.D.</i>		DEGREE <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys.		23B. DATE SIGNED <i>6-25-69</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/27/69</i>		24C. NAME of CEMETERY or CREMATORY <i>NAT'L MEM. PARK</i>	
24D. LOCATION (City, town, or county) (State) <i>FALLS CHURCH VA.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1969</i>			
25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc. 6415 Belair Rd.</i>			

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Handwritten text, possibly a date or reference number, located below the header.

Handwritten text, possibly a name or subject, located in the middle left of the page.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6646

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY E. DIETZ

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

June 26, 1969

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 26, 1969

12:55 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

27 38

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Female

7. RACE

White

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9. DATE OF BIRTH

April 21, 1908

10. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1239 Meridene Drive

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHICH COUNTRY?

U.S.A.

13. FATHER'S NAME

John A. Bleach

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Home M'ker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Cona Barber

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. June Snyder - 1239 Meridene Drive

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hypertensive and arteriosclerotic

(A) IMMEDIATE CAUSE

cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 26, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-30-69

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1969

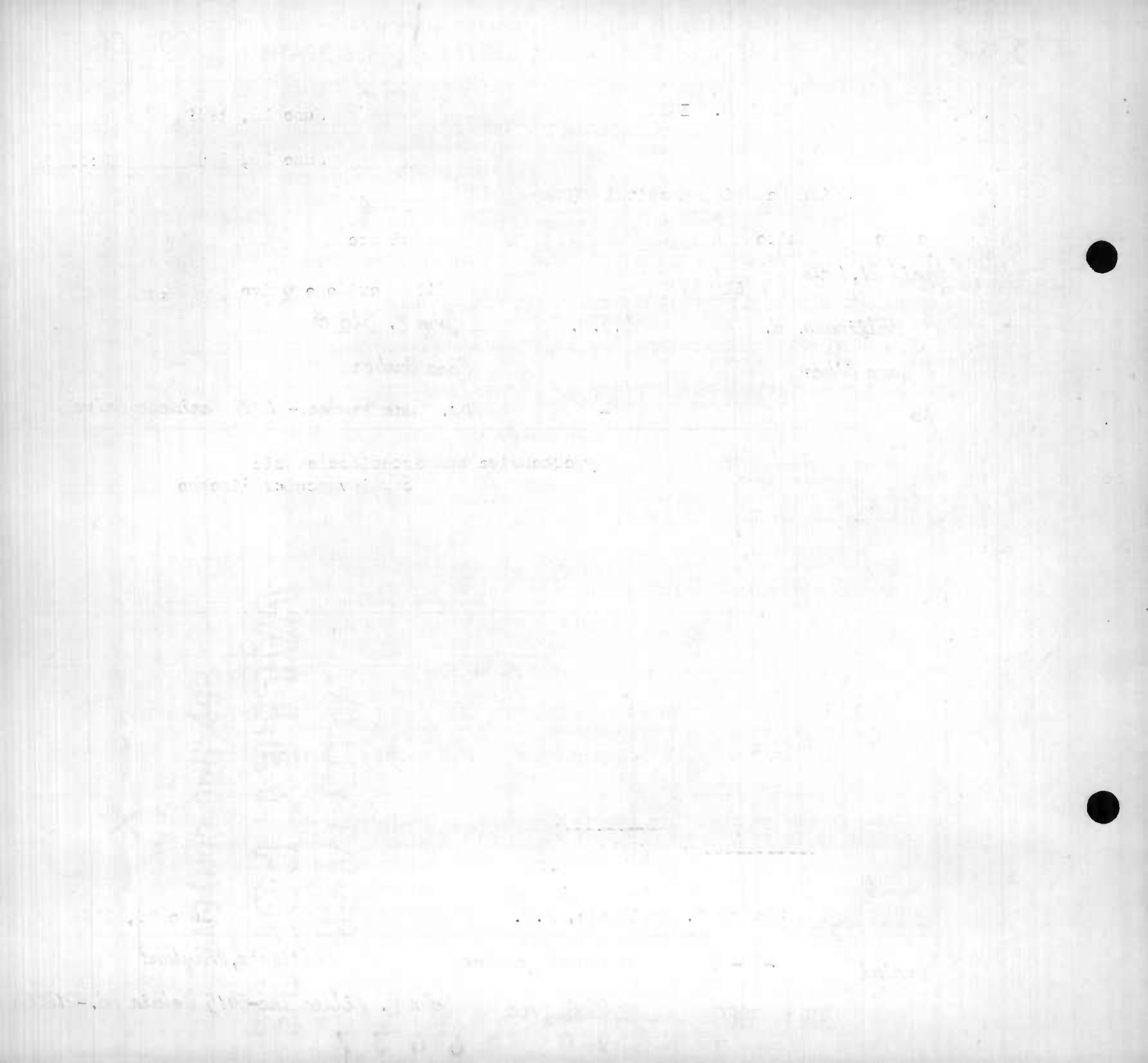
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Rd.-21206

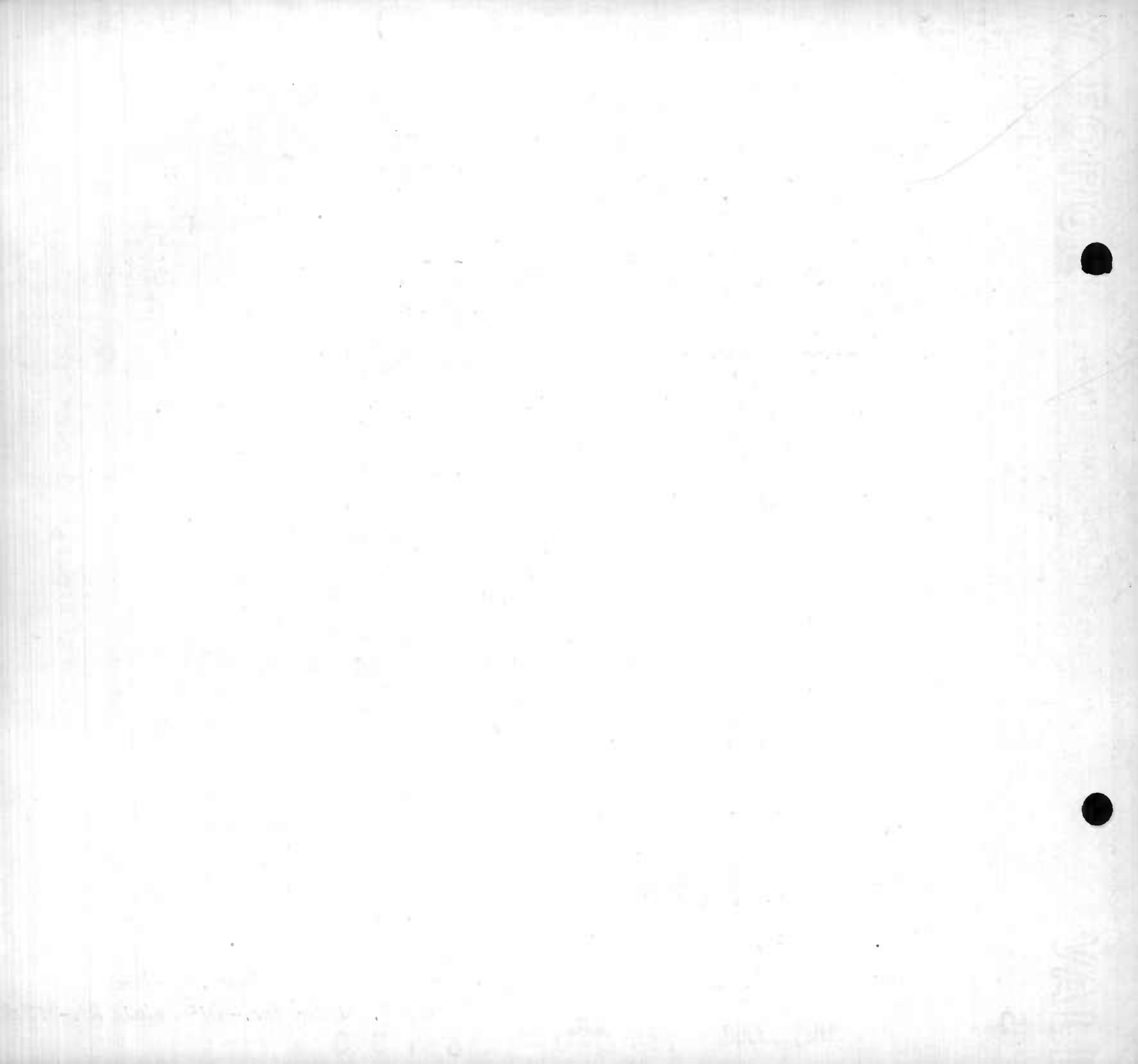
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-400 69 6647				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6647	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				YEWELL, MARY C.		6/26/69 1 455 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 4940 EASTERN AVE. 21224 BALTIMORE CITY HOSPITALS				A. STATE Maryland		B. COUNTY 2633	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3611 Belair Rd. 21213 007			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-06	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Yewell Ward				14. MOTHER'S MAIDEN NAME Johanna Ryan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT BCH Records: 4940 Eastern Ave. 21224	
18. 244X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO-RESPIRATORY ARREST (B) FEVER UNKNOWN CAUSE (C) COMA - MYXEDEMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 2 DAYS 3 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				HYPONATREMIA CONVULSION		8 DAYS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/18 19 69 to 6/26 19 69, that (I) (we) last saw the deceased alive on 6/26 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. Valdmanis MD				23B. DATE SIGNED 6/26/69			
23C. PHYSICIAN'S NAME (Type) V. Valdmanis, MD				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Ave. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-69		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR G. E. Taylor, M.D.		25C. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd. - 21206		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

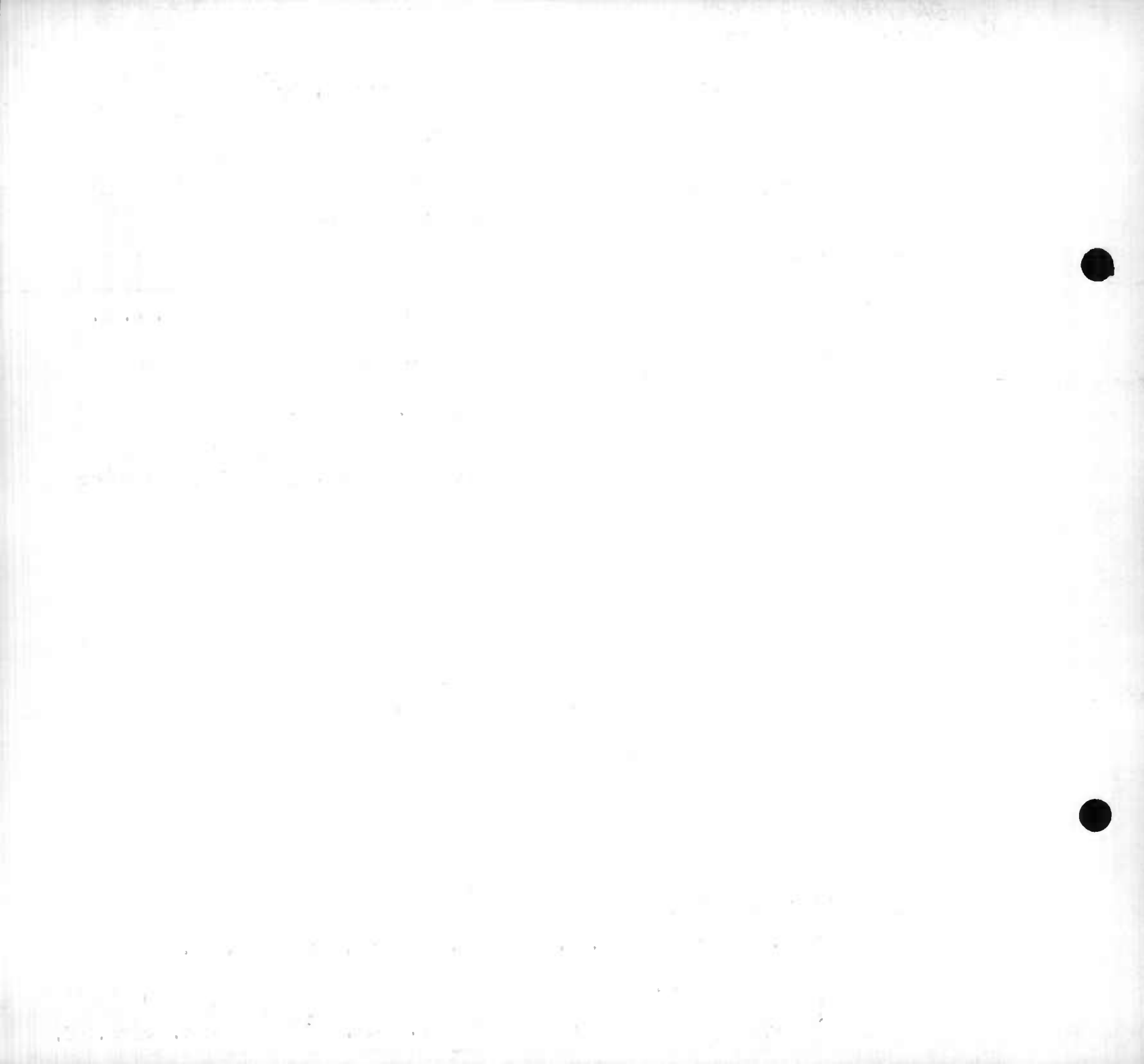
69 6648 BALTIMORE CITY HEALTH DEPARTMENT X		69 6648	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
STEPHEN WEST		6/28/69 6:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE & COUNTY	
MARYLAND GENERAL HOSPITAL Maryland General Hospital		Maryland Baltimore 5300	
5. SEX		6. RACE	
Male		white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		5/23/10	
9. AGE (In years lost birthday)		10. BIRTHPLACE (State or foreign country)	
59		Baltimore Co. Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baltimore Co. Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Andrew T. West		Agnes Prozdowski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		213-07-9950	
17. INFORMANT		ADDRESS	
Mrs. Antonetta R. West		Same Above	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
6/26/69		INGUINAL + FEMORAL HERNIA	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
YES		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from		19 to 19	
that (we) lost saw the deceased alive on		and that in (our) opinion death occurred on the date	
and hour and from the causes stated above. (We) (did) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Jale P. Baker M.D.		6/28/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
JOLE P. BAKER M.D.		MARYLAND GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		7/2/69	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Meadowridge Memorial Park		Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JUL 1 1969		John E. Duda, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
John J. Duda		7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

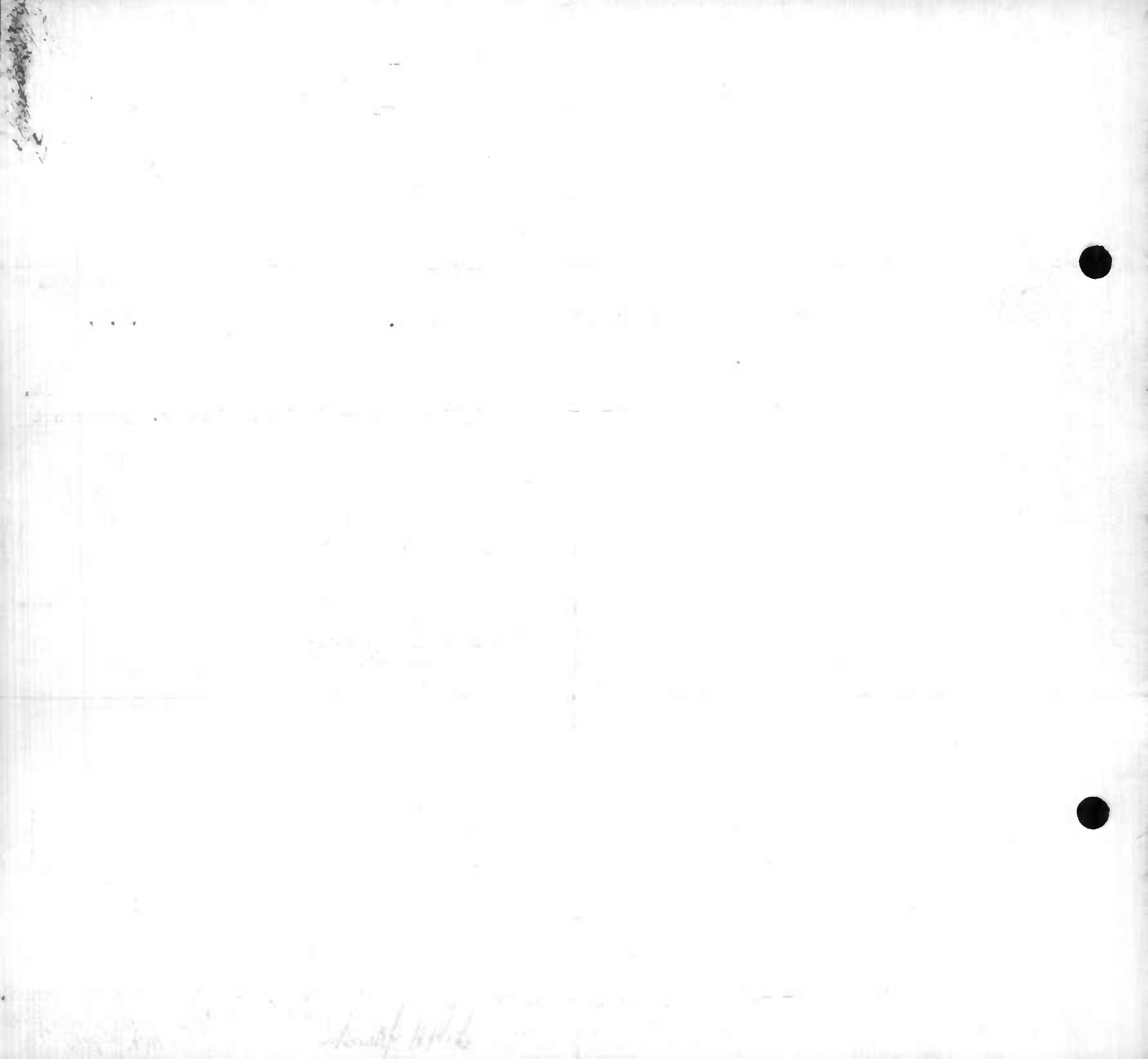
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6649
<div style="display: flex; justify-content: space-between;"> <div> <p>ON APPROVAL 154</p> <p>MEDICAL EXAMINER 69 6649</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> </div>				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Eleanor Gorecki		June 26, 1969 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2200 Fleet Street		A. STATE Maryland		
		B. COUNTY		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2200 Fleet Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/95	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Frank Banack		14. MOTHER'S MAIDEN NAME Josephine Gregorek		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Son: Rev. Joseph M. Gorecki	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.		CAUSE OF DEATH IMMEDIATE CAUSE ARTERIOSCLEROTIC DISEASE DUE TO, OR AS A CONSEQUENCE OF: HEART DISEASE Sudden APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Irvin B. Kaplan M.D.			23B. DATE SIGNED 6/27/69	
23C. PHYSICIAN'S NAME (Type) Irvin B. Kaplan M. D.			23D. ADDRESS 129 S. Broadway, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/30/69	24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969	25B. NAME OF REGISTRAR John E. Taylor, M.D.	25C. FUNERAL DIRECTOR John J. Duda	ADDRESS 2829 Hudson St. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6650				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 6650	
1. NAME OF DECEASED (Type or Print) CHERYL ELANNE STRUNCK				2. DATE AND HOUR OF DEATH 6-27-69 7.25 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY V-35 C. CITY OR TOWN McKEESPORT D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 117 OBERDICK DRIVE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-44	9. AGE (In years last birthday) 25	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher				10B. KIND OF BUSINESS OR INDUSTRY Educational		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM S.				14. MOTHER'S MAIDEN NAME MARGARET DUVAL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 208-38-4902		17. INFORMANT William Strunck 117 Oberdick Dr. McKeesport Pa.			
18. 746.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante Renal failure DUE TO, OR AS A CONSEQUENCE OF: 7 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 1 episode of hypertension DUE TO, OR AS A CONSEQUENCE OF: 8 days									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Tendency of Fallot									
19A. DATE OF OPERATION 6/26/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED telemetry attached		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx) 8/11		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 8/11					
22. I certify that (I) (this hospital) attended the deceased from 8/11 19 69 to 6/27 19 69 that (I) (we) last saw the deceased alive on 6/27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert S. Kuntz				23B. DATE SIGNED 6/28/69		23C. PHYSICIAN'S NAME (Type) Robert S. Kuntz			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-1-69		24C. NAME OF CEMETERY OR CREMATORY Nt. Vernon Cemetery		24D. LOCATION (City, town, or county) (State) Elizabeth, Township Allegheny Penna.			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Jacob, M.D.		25C. FUNERAL DIRECTOR MELVIN JAY		25D. ADDRESS 2702 O'NEILL BLVD McKEESPORT - PA.			



FUNERAL DIRECTOR: IMPORTANT

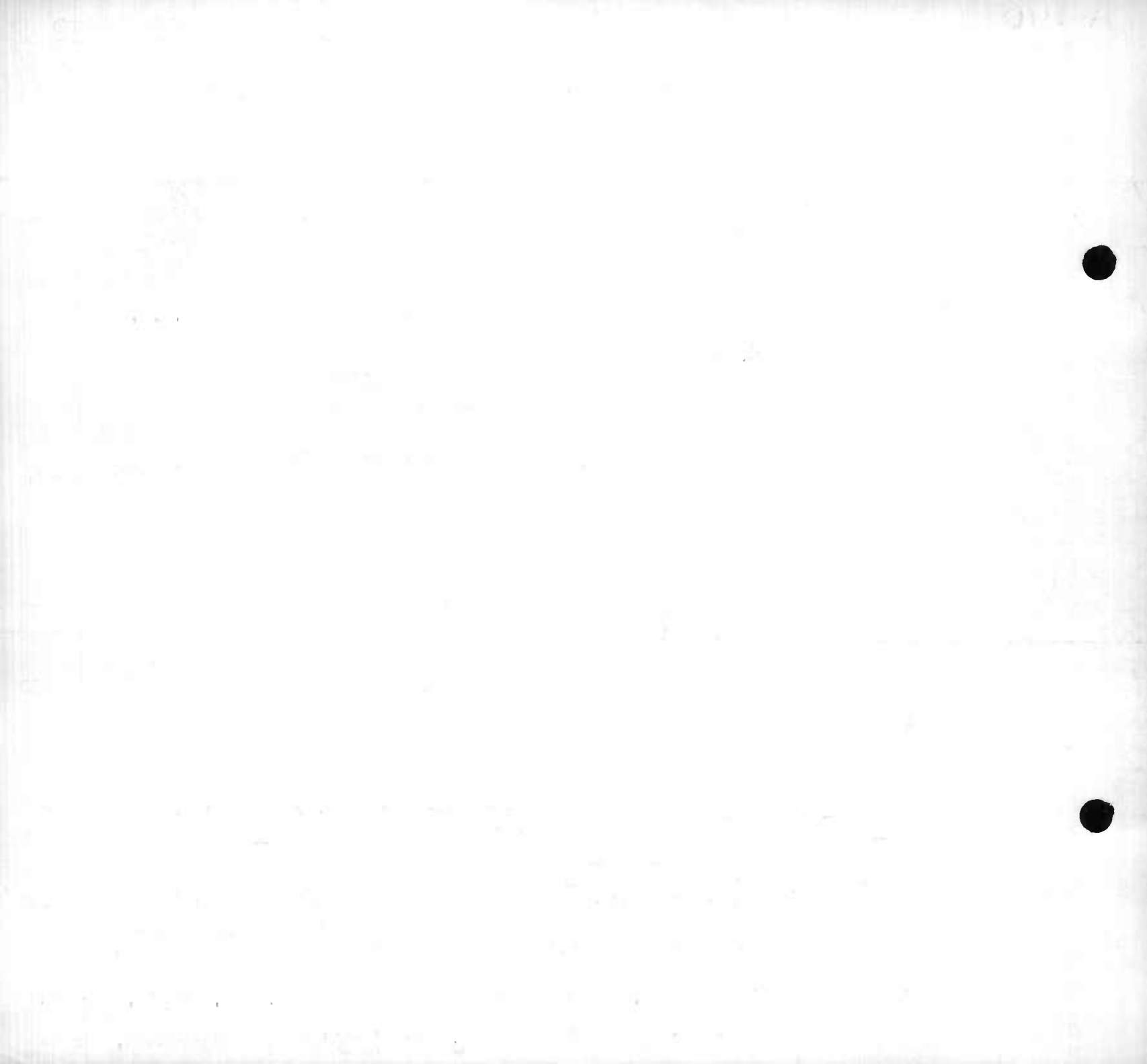
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO.		69 6651		69 6651	
1. NAME OF DECEASED (Type or Print)		GERTIE V. MOORE		2. DATE AND HOUR OF DEATH JUNE 25 1969 10:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL		A. STATE MARYLAND		B. COUNTY 604	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
35		E. STREET AND NUMBER 17 N. WASHINGTON ST. 21231			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1893	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM MAY		14. MOTHER'S MAIDEN NAME VIOLA LANBOES		12. CITIZEN OF WHAT COUNTRY? AMERICA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-22-6537		17. INFORMANT Albert McCoobie Charlottesville, Va.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE - YEARS (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: (C) YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 28 1969 to June 15 1969 that (I) (we) last saw the deceased alive on June 15 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cezar A. Lopez MD.		23B. DATE SIGNED 6/26/69		23C. PHYSICIAN'S NAME (Type) CEZAR A. LOPEZ MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-28-69		24C. NAME OF CEMETERY OR CREMATORY Greenwood Co. Mem. Gardens, Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR J. E. J. M.D.	
25C. FUNERAL DIRECTOR Gerald D. Minnick		25D. ADDRESS Baltimore, Md.		25E. ADDRESS Baltimore, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

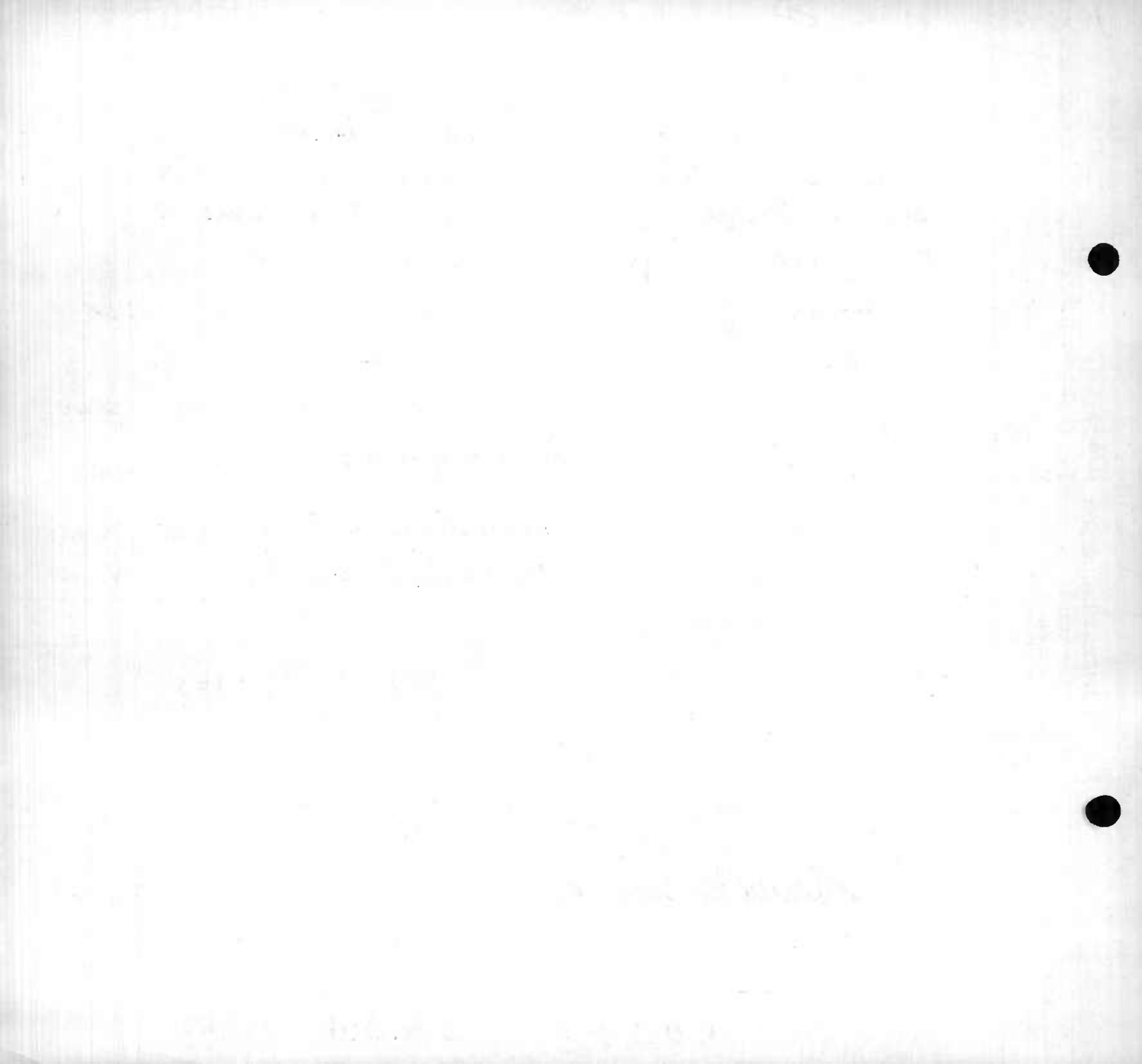
BIRTH NO. <u>pid.</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 6652</u>	
1. NAME OF DECEASED (Type or Print) <u>Marquerite A. Abell</u>		2. DATE AND HOUR OF DEATH <u>June 27, 1969</u> <u>3:50 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>BALTIMORE Co</u> <u>21221</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>1104 TACE DRIVE</u>		<u>53-00</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-64</u>	9. AGE (in years last birthday) <u>4</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>JOSEPH A. ABELL</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA EDMINATON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> same as # 4 above	
18. <u>192.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Neuroblastoma, metastatic, diffuse</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(3)</u> (this hospital) attended the deceased from <u>June 19</u> 19 <u>69</u> to <u>June 27</u> 19 <u>69</u> that <u>(1)</u> (we) last saw the deceased alive on <u>June 27</u> 19 <u>69</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Van C. Joffrion MD</u>				23B. DATE SIGNED <u>June 27, 1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>VAN C. Joffrion MD</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSP.</u> <u>Baltimore, Md 21212</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/29/1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Johns Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Hollywood, St. Mary's, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>			



FUNERAL DIRECTOR: IMPORTANT

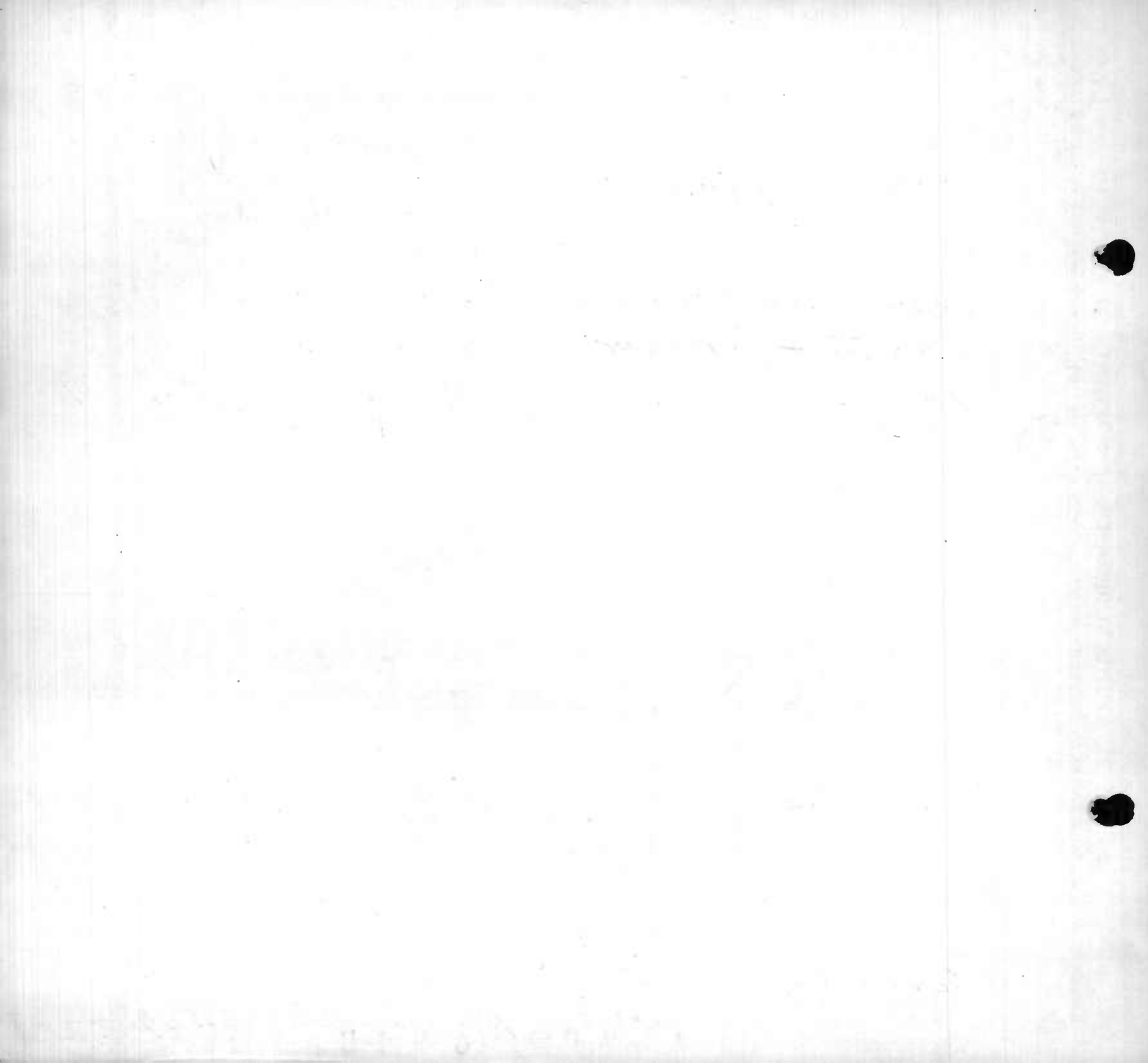
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6653	
BIRTH NO. 69 6653		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MAURICE A. DAVIS			2. DATE AND HOUR OF DEATH 7-1-69 8 ⁴⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Balto. Gen. 3001 S. HANOVER			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 146 W. HAMBURG ST.		
5. SEX M	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASH. D.C.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME UNKWN		
14. MOTHER'S MAIDEN NAME UNKWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT FRIEND - DOROTHY BROOKS		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) ACUTE RESPIRATORY FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE AIRWAY DISEASE YEARS		
			(B) DUE TO, OR AS A CONSEQUENCE OF: HEALED PULMONARY T.B. YEARS		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-23 19 69 to 7-1 19 69, that (I) (we) last saw the deceased alive on 7-1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald M. Wood MD				23B. DATE SIGNED 7-1-69	
23C. PHYSICIAN'S NAME (Type) Donald M. Wood		23D. ADDRESS South Baltimore General			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-69		24C. NAME OF CEMETERY or CREMATORY Mount Auburn	
24D. LOCATION Baltimore City					
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Webb, MD		25C. FUNERAL DIRECTOR Isaac L. Brown and Son 108 W. Montgomery Street	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 69 6654	
CERTIFICATE OF DEATH											
BIRTH NO. 69 6654											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Bryant Anna					2. DATE AND HOUR OF DEATH 6/30/69 12:35 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 1607						
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hosp. in Md.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore						
					D. STREET ADDRESS (If rural, give location) 1501 Duxeland St.						
5. SEX F	6. RACE N.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 4-1-95	9. AGE (In years last birthday) 74	11. Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Martinsburg Va.					
13. FATHER'S NAME Dawson - Pritchett					14. MOTHER'S MAIDEN NAME Alie Martin						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Lillie Harris 2409 Futura Pl			ADDRESS		
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) Pneumonia DUE TO (B) CVA DUE TO (C) ASCVD					INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 6/27 19 69 to 6/30 19 69 , that (I) <u>(we)</u> last saw the deceased alive on 6/30 19 69 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.											
23A. SIGNATURE Edward L. Park M.D.								23B. DATE SIGNED 6/30/69			
23C. PHYSICIAN'S NAME (Type) Edward L. Park M.D.								23D. ADDRESS 1730 Ashburton St. Balto. 21216			
24A. BURIAL CREMATION REMOVAL (Specify)			24B. DATE 6/1/69		24C. NAME OF CEMETERY OR CREMATORY Washington Cemetery			24D. LOCATION (City, town, or county) (State) WASHINGTON PA			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969			25B. NAME OF REGISTRAR Robert E. Talbot M.D.			25C. FUNERAL DIRECTOR Marjorie Phillips 638 N. Gibson St			ADDRESS		



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5354

69 6655

BALTIMORE CITY HEALTH DEPARTMENT

69 6655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LETITIA STANLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 27, 1969 Hour 2:55 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MD. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1969 2:55 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12/20/1944		10. AGE (In years lost birthday) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. McNEALL		14. MOTHER'S MAIDEN NAME Lucille Stewart	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		16. KIND OF BUSINESS OR INDUSTRY Diner Room	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO. Major James Portersburg VA	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 304.9	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2/2/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/27/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/2/69	
24C. NAME OF CEMETERY or CREMATORY MT AUBURN		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Marshall D. Long		ADDRESS 638 N. C. m. n.	

WALLACE J. PROBERTS

1850-1910

My dear Mr. Proberts

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S-524

69 6656 BALTIMORE CITY HEALTH DEPARTMENT

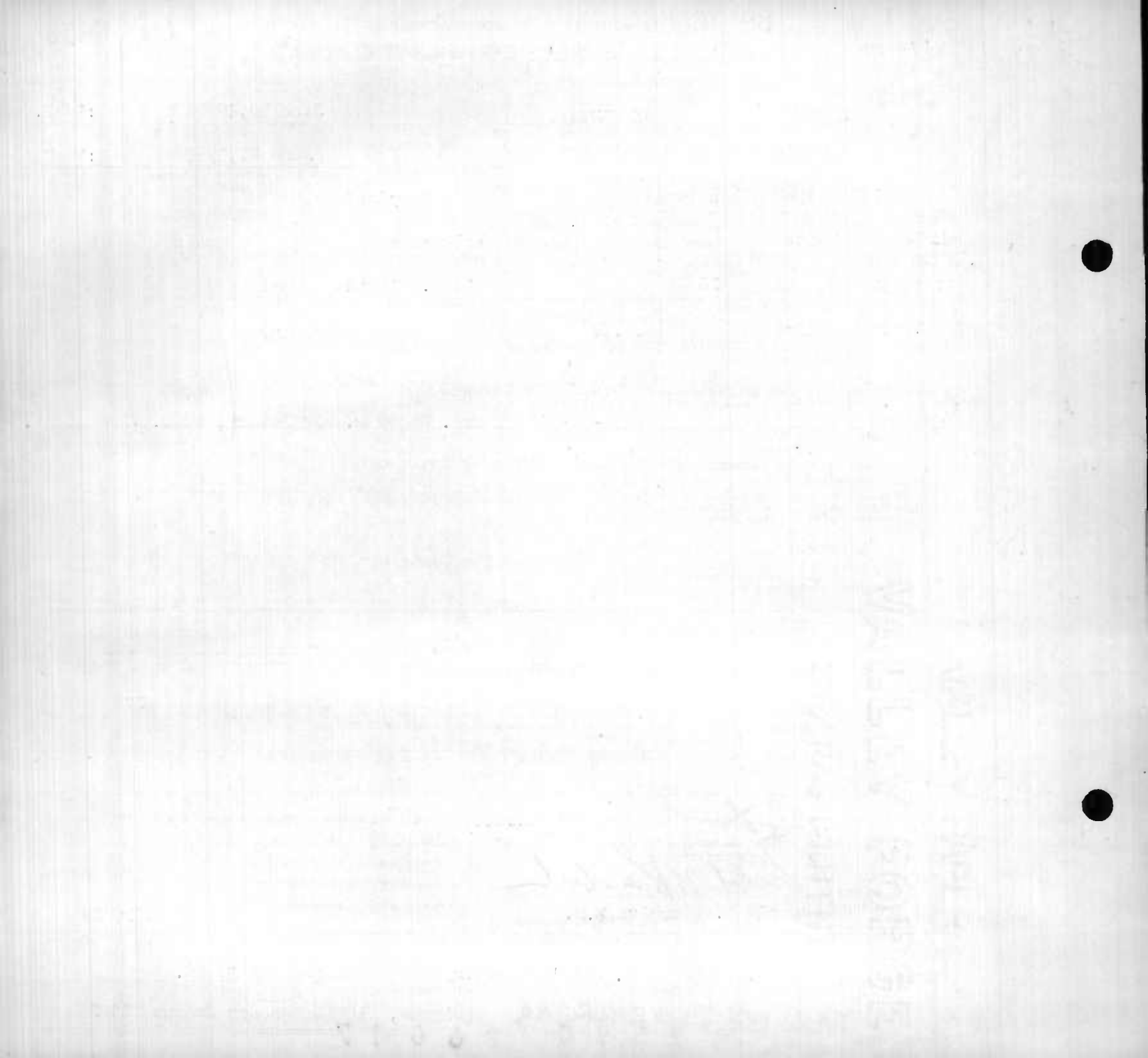
69 6656

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES SINGLETARY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1969 Hour 4:18 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1700 Block Aiken Street		3. DATE PRONOUNCED DEAD Month Day Year June 29, 1969 Hour 4:18 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1903			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11/19/32		10. AGE (In years lost birthday) 36 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Singletary		14. STREET AND NUMBER 26 S. Vincent Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		14B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
15. MOTHER'S MAIDEN NAME Edith Baxley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown	
17. SOCIAL SECURITY NO. 217-26-9496		18. INFORMANT Mrs. James W. Singletary, 206 S. Vincent St.	
19. CAUSE OF DEATH Intravenous narcotism (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7/2/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/30/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/69	
24C. NAME OF CEMETERY or CREMATORY St. John's Cemetery		24D. LOCATION (City, town, or county) (State) Ellicott City, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Avenue 21229			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 6657		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6657	
1. NAME OF DECEASED (Type or Print) STREIMAN, ADA Garline				2. DATE AND HOUR OF DEATH JULY 1, 1969 2:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2834			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 22 S. Athol Avenue			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/15/89	9. AGE (In years last birthday) 81 79	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME THOMAS TROGLER				
14. MOTHER'S MAIDEN NAME EMMA TROGLER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE				
16. SOCIAL SECURITY NO. 219-10-8080			17. INFORMANT ADDRESS ST. AGNES HOSPITAL				
18. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio respiratory failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute cardiac failure & pulmonary edema (B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic myocardial degeneration & chronic failure (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 1 1969 to JULY 1 1969 that (I) (we) last saw the deceased alive on JULY 1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William James Bryson M.D.				23B. DATE SIGNED 07/01/69		23C. PHYSICIAN'S NAME (Typed) W. BRYSON, M.D.	
23D. ADDRESS 4605 Edmondson Ave Balto Md 21229							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
BIRTH NO. 69 6658		CERTIFICATE OF DEATH		69 6658
1. NAME OF DECEASED (Type or Print) RUTH MACFADDEN		2. DATE AND HOUR OF DEATH 6/30/69 4:01 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND General Hosp. 48		A. STATE Maryland B. COUNTY 2005		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2246 Wilkens Ave.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/90	9. AGE (in years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME FRANK Thorele		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218 22 2015		17. INFORMANT Mr. Wm. T. Mac Fadden, 2246 Wilkens Ave.
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UREMIA (B) CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF: (C) CHF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 31 DAYS
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from 5/29/69 to 6/30 19 69 that (2) (we) last saw the deceased alive on 6/30 19 69 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.				
23A. SIGNATURE B. Ann Ward, M.D.		23B. DATE SIGNED 6/30/69		23C. PHYSICIAN'S NAME (Type) B. Ann Ward,
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		

FUNERAL DIRECTOR: IMPORTANT

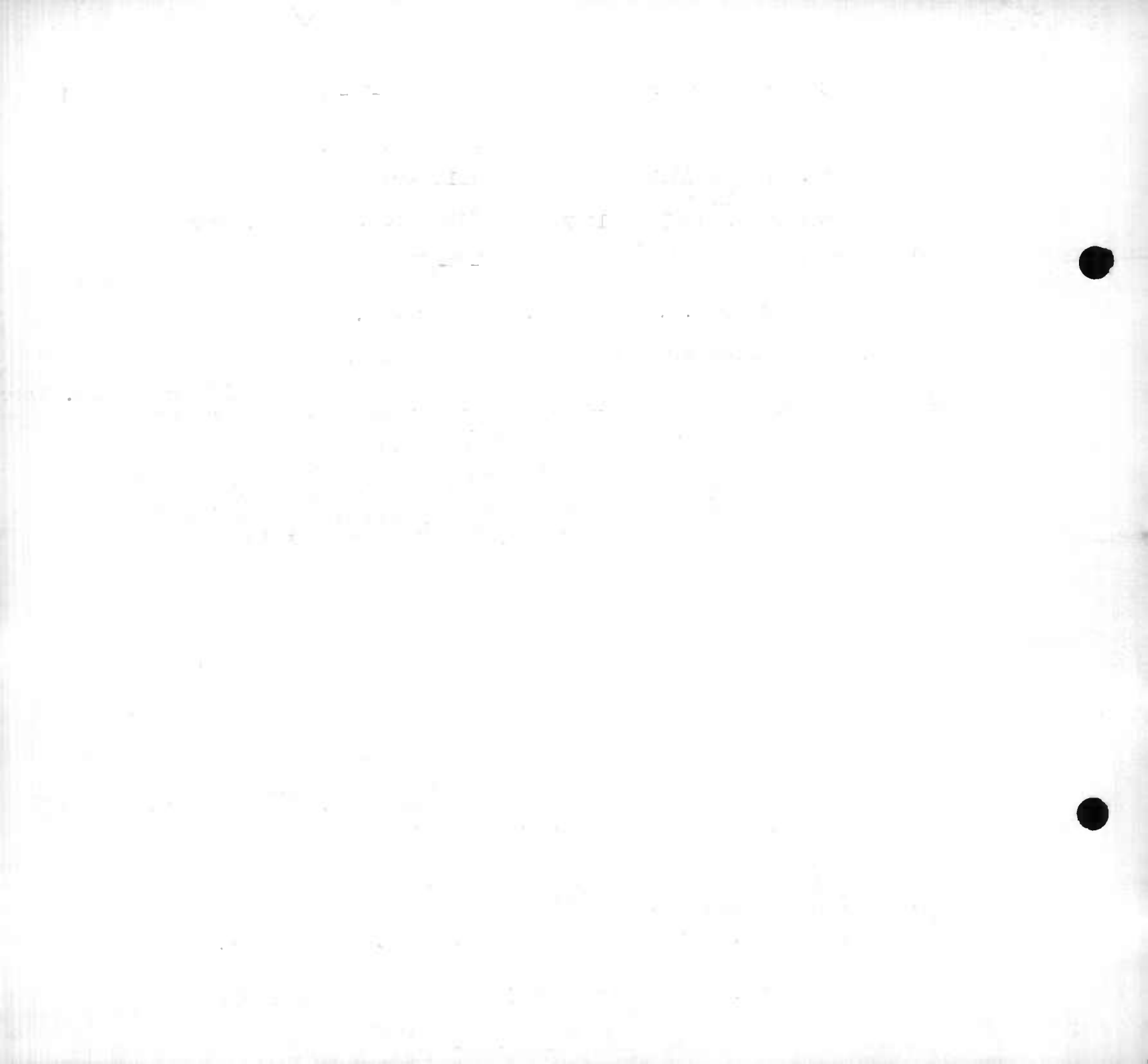
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 6659				69 6659	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Ernest N. Kahle</u>				June 28, 1969 9 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE Where deceased lived, If institution: residence before admission	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hosp.</u>				A. STATE <u>XXXX Pa.</u> B. COUNTY <u>V-35</u>	
C. CITY OR TOWN <u>Van</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>621 Murdock Rd.</u>				Route #1	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/09/02</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supt.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U-S.</u>		13. FATHER'S NAME <u>Edward T. Kahle</u>			
14. MOTHER'S MAIDEN NAME <u>Martha Went</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Kathryn Kahle 621 Murdock Rd.</u>			
18. <u>403 X I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Possible CVA</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF:	
(C) <u>Nephrosclerosis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 25</u> 19 <u>69</u> to <u>June 28</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>June 28</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Charles R. Goshen</u>				23B. DATE SIGNED <u>6/28/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. CHARLES R. GOSHEN MD.</u>				23D. ADDRESS <u>UNION MEM. HOSP. BALTO. MD. 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/2/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Perry Cemt. Fertigs,</u>	
24D. LOCATION <u>Fertigs</u>		24E. CITY, TOWN, OR COUNTY <u>Penna.</u>		24F. STATE <u>Penna.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>	
25D. ADDRESS <u>6500 York Rd.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

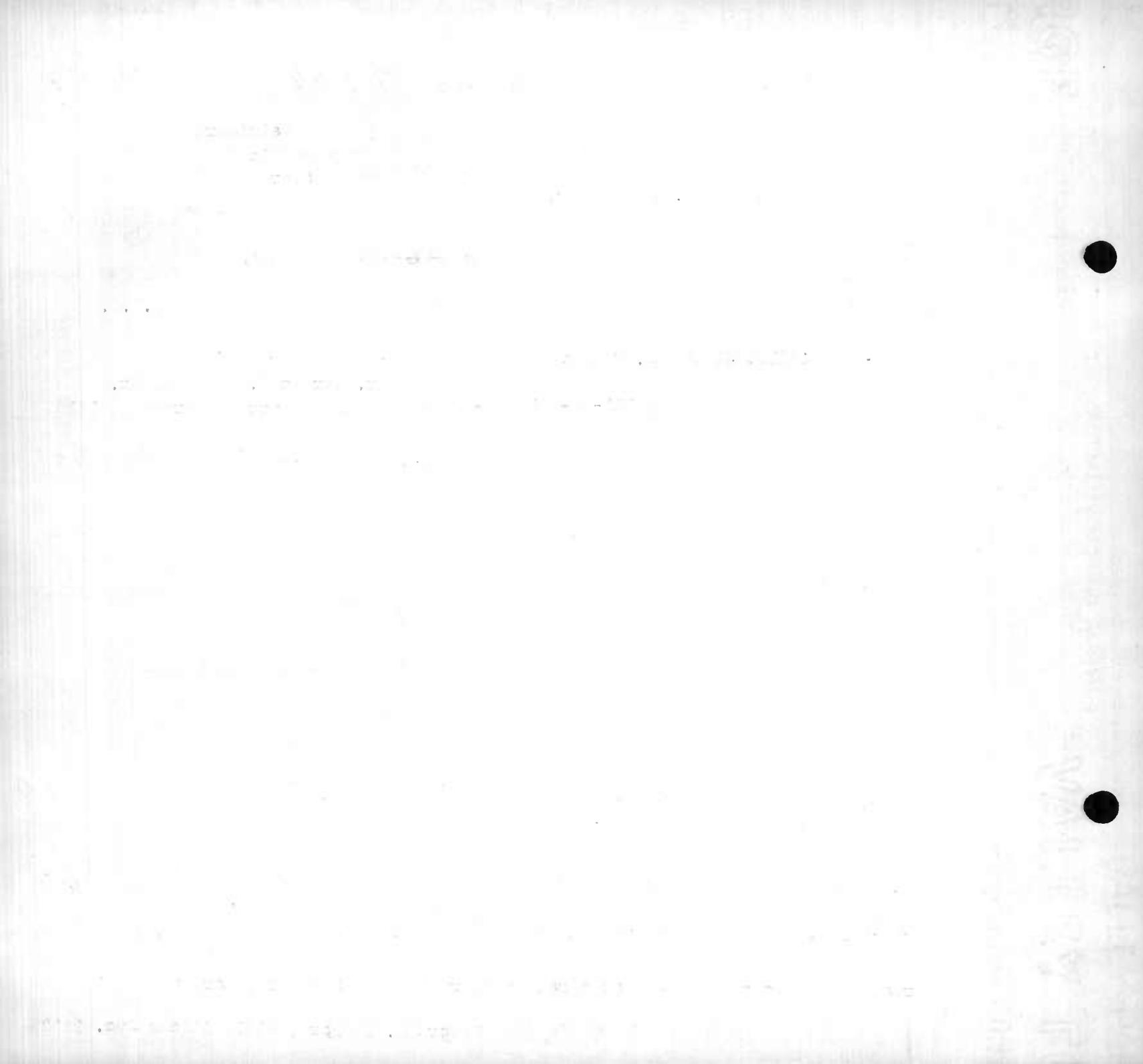
B-6201		69 6660		BALTIMORE CITY HEALTH DEPARTMENT		X		69 6660	
BIRTH NO.				CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) Chauncey - Brooks				2. DATE AND HOUR OF DEATH 6-28-69 1 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland 21229				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland (21207) B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6216 Liberty Heights Terrace					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-95 1896	9. AGE (In years last birthday) 73 74x	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Project Engineer				10B. KIND OF BUSINESS OR INDUSTRY E.I. Dupont Co.		11. BIRTHPLACE (State or foreign country) Suffock, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Phelps Brooks				14. MOTHER'S MAIDEN NAME Adele Jones					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none				16. SOCIAL SECURITY NO. 216-07-1106		17. INFORMANT ADDRESS 6216 Liberty Hgts. Terr Mrs Frances Murphy Brooks			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 492X I Acute Cardiac Arrest Marked Pulmonary Emphysema Obstructive Airway Disease Acute Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from May 19 55 to 28 June 19 69 that (I) (we) last saw the deceased alive on 27 June 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph E. Muse Jr. M.D.				23B. DATE SIGNED 28 June '69					
23C. PHYSICIAN'S NAME (Type) Joseph E. Muse				23D. ADDRESS 2725 N. Charles St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1, 1969		24C. NAME of CEMETERY or CREMATORY Elkton Cemetery		24D. LOCATION (City, town, or county) (State) Elkton, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR General Estate		ADDRESS 136 Edmondson Ave. Catonsville, MD 21228			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

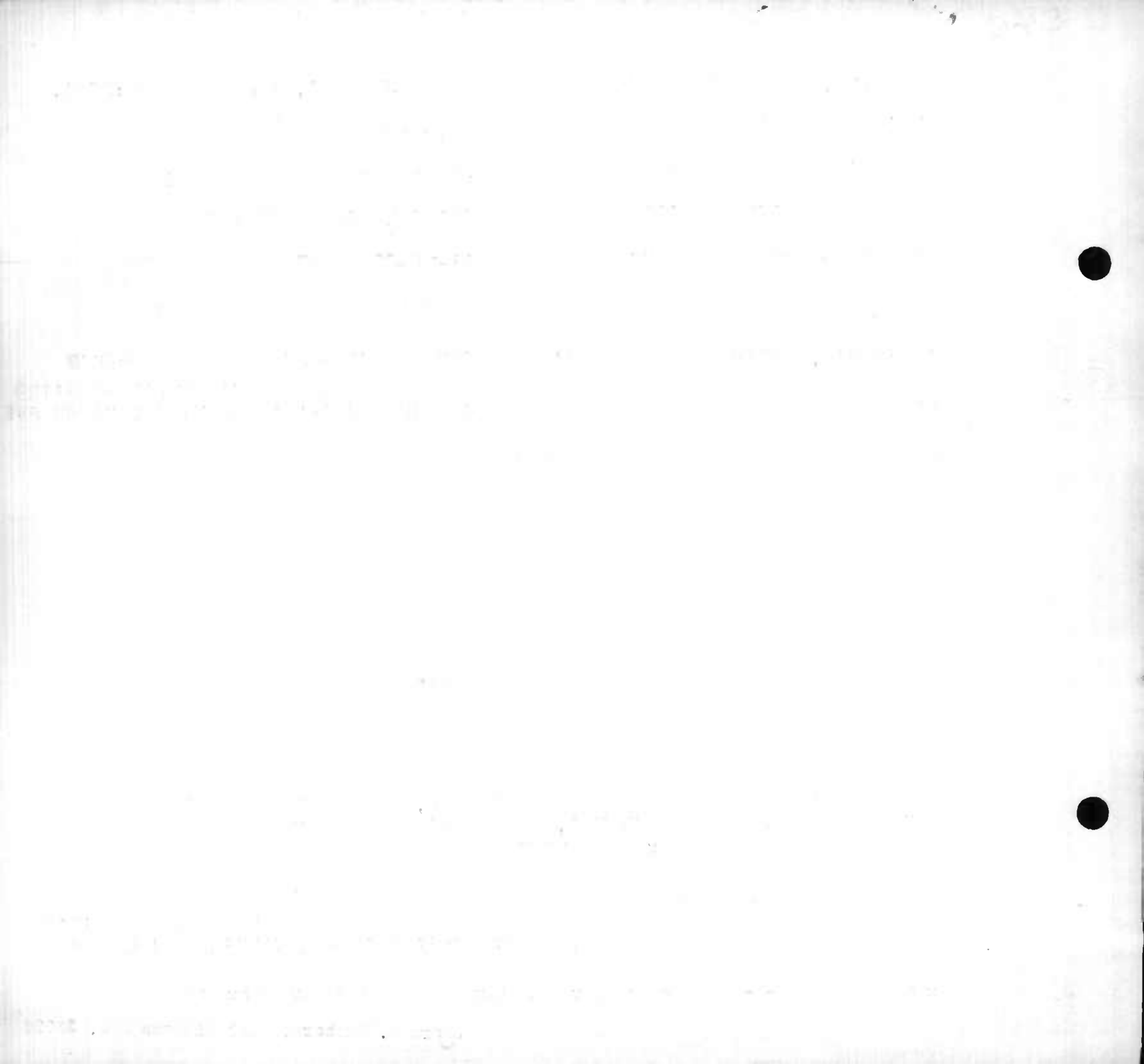
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6661
CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARGARET A. COLLINS		2. DATE AND HOUR OF DEATH 7-1-69 5:40 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300		
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 5900 Carroll Street 21207		
5. SEX Fe	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-13	9. AGE (In years last birthday) 55 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH GUMPMAN A. Gumpman		
14. MOTHER'S MAIDEN NAME SARA H. Roberts		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-03-6620		17. INFORMANT Mr. Jerome J. Collins, Sr. XXXXXXXXXX 5900 Carroll Street 21207		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH BRONCHOGENIC C.A. (oat cell type) (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF: YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6-1-69 to 7-1-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Agustin del Campo MD		23B. DATE SIGNED 7-1-69		23C. PHYSICIAN'S NAME (Type) Agustin del Campo MD
23D. ADDRESS BON SECOURS BALTIMORE MD		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-5-1969		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

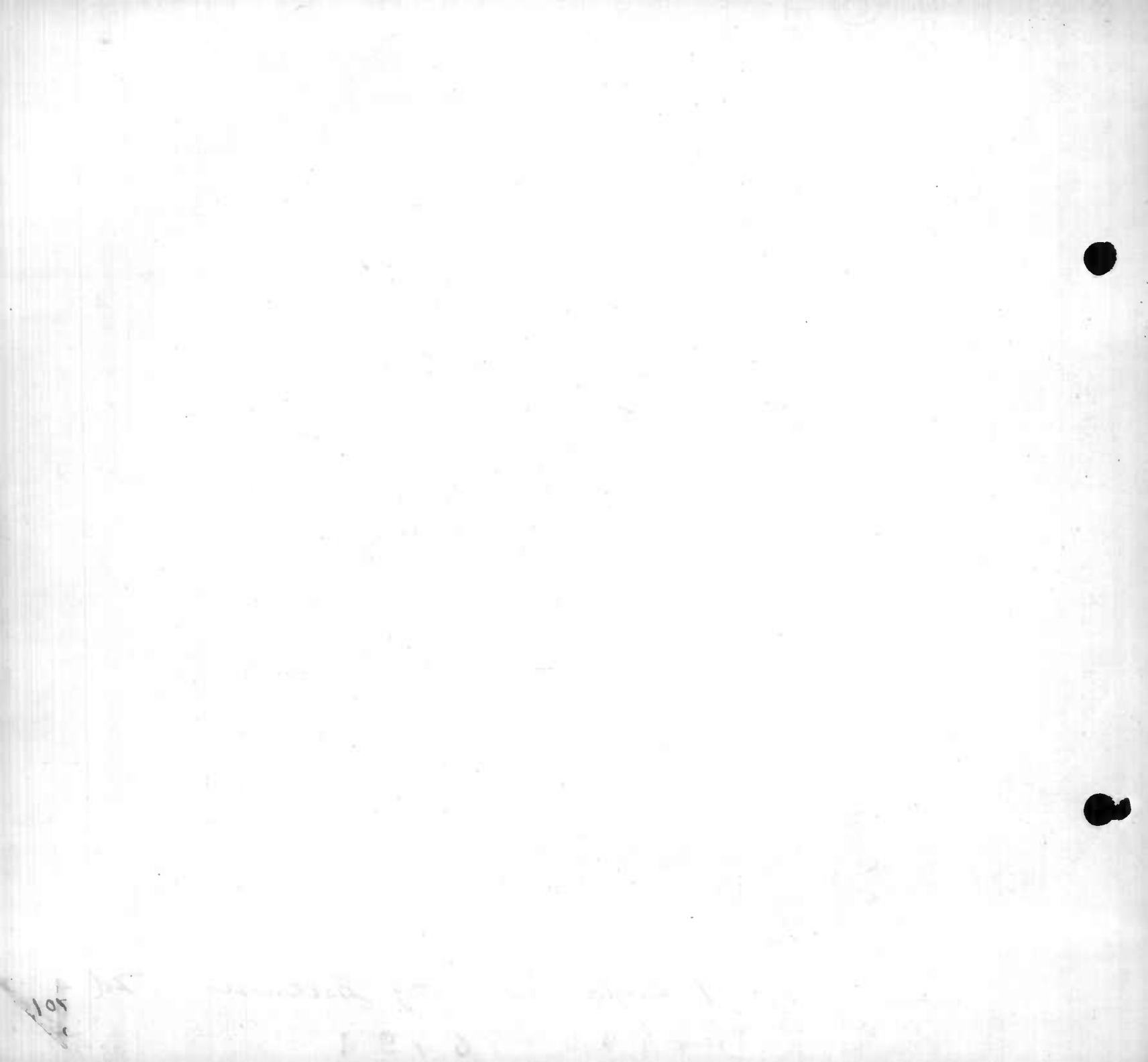
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6662</u>
BIRTH NO. <u>69 6662</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type in Print) CONNELLY, MARGARET ISABELLE		2. DATE AND HOUR OF DEATH JULY 01, 1969 6:20 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS & CATON AVENUES BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY <u>20-02</u> C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 523 S LONGWOOD STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-03	9. AGE (In years last birthday) 65 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALOYSIUS, RITCHER DEC 'D		
14. MOTHER'S MAIDEN NAME (DONNELLY) MARY DEC 'D		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Caudalgia stroke - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last Acute Pericarditis I. DUE TO, OR AS A CONSEQUENCE OF: A.S. C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 104 - 2 days -				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from JUNE 29, 1969 to JULY 1, 1969 that (X) (we) lost saw the deceased alive on JULY 1, 1969 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Alexandro Mejia</i> DEGREE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ALEXANDRO MEJIA MD DEGREE
23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR <i>James E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

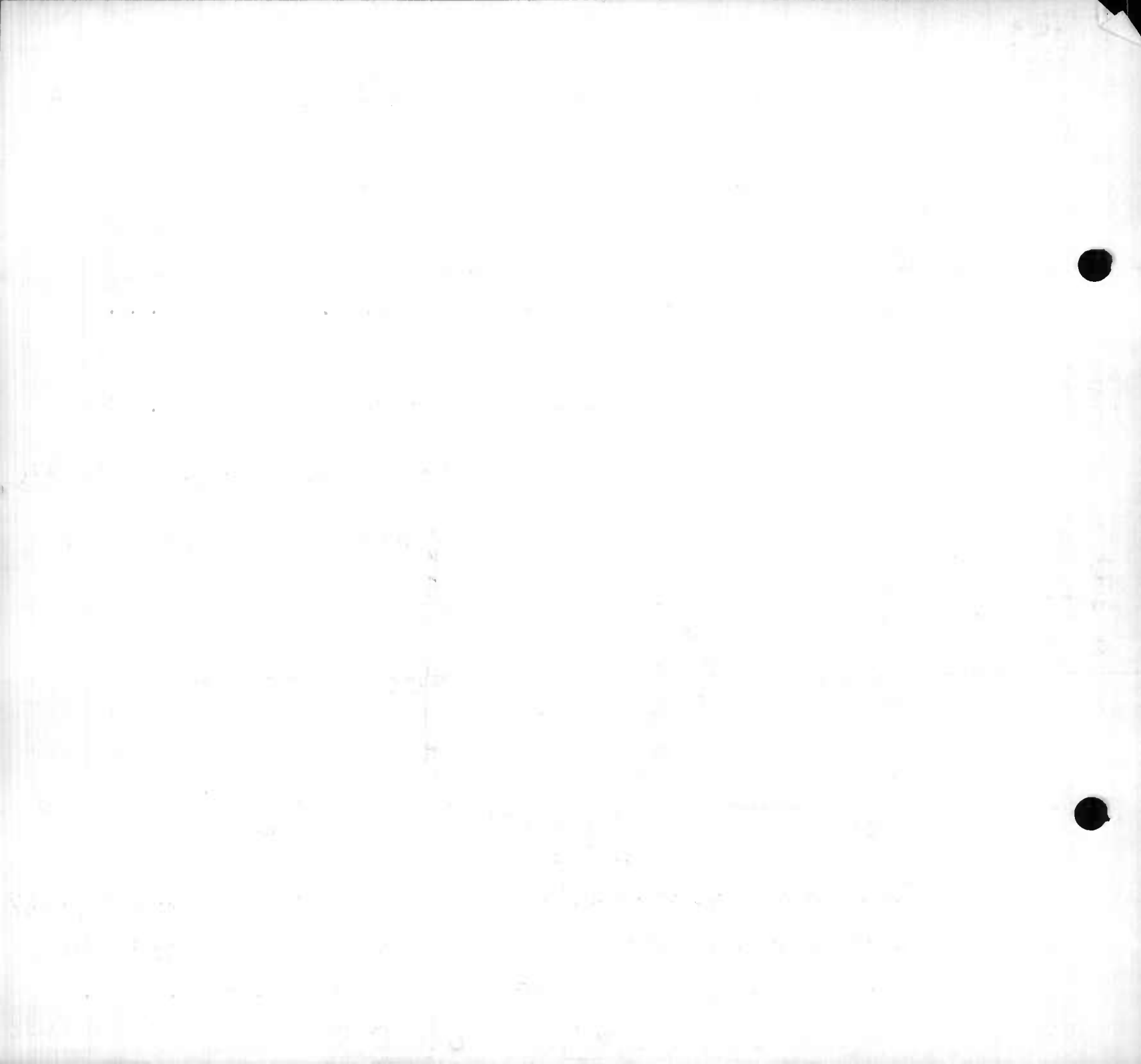
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
69 6663		69 6663		69 6663
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ANNAC Burkett</u>		
2. DATE AND HOUR OF DEATH <u>July 1, 1969 1:40 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harborview Nursing & Convalescent Center</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>605 Scott St (21230)</u>		5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>4/7/91</u> 9. AGE (In years lost birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Patrick Flynn</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hogan</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>		
17. INFORMANT <u>Nursing Home Records</u>		ADDRESS		
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>		<u>3 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Influenza-like illness</u>		<u>year</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 25</u> 19 <u>69</u> to <u>July 1</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>July 1</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. E. Alvarez</u> DEGREE		23B. DATE SIGNED <u>July 1, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>A. E. ALVAREZ M.D.</u> DEGREE
23D. ADDRESS <u>1209 St. Paul St.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>
24D. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>		25B. NAME OF REGISTRAR <u>Wm. E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Morgan & Son Inc.</u>
				ADDRESS <u>901 Hollins St. 23, Md.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 6664		69 6664		69 6664	
1. NAME OF DECEASED (Type or Print) PHILANDER RIES		2. DATE AND HOUR OF DEATH 6/29/69 3:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4508 PARKMONT AVE 21206					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-11	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting		10B. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Hospi		11. BIRTHPLACE (State or foreign country) Cordova, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME LAURITZ RIES		14. MOTHER'S MAIDEN NAME MARGARET MUENCH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-2689		17. INFORMANT Mrs Ruth Ries 4508 Parkmont Ave. 21206	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA LUNG		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
(B) CEREBRAL METASTASES		DUE TO, OR AS A CONSEQUENCE OF: 1/2 YR.			
(C) _____					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/23 1969 to 6/29 1969 that (I) (last) saw the deceased alive on 6/28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Seymour Levine, M.D.				23B. DATE SIGNED June 29, 1969	
23C. PHYSICIAN'S NAME (Type) SEYMOUR LEVINE		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-2-1969	24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR John E. Tule, M.D.		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236	



W 252 1

69 6665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 6665

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frances Wisniewski

2. DATE AND HOUR OF DEATH

June 29, 1969

1:45 a.m. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2834 Hudson Street

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2834 Hudson Street

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

July 15, 1885

9. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

POLAND

13. FATHER'S NAME

Depczynski

14. MOTHER'S MAIDEN NAME

? ?

15. Was Deceased Ever in U. S. Armed Forces?

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-54-6006

17. INFORMANT (Granddaughter)

ADDRESS

Miss Dolores Wajer, 2834 Hudson St. Balto. Md.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Cardio Vascular

30 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Old AGE

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____
that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Artemio M. Arciaga, Jr.

DEGREE

Attending ☒
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

6/30/69

23C. PHYSICIAN'S
NAME (Typo)

Artemio M. Arciaga, Jr. M.D.

23D. ADDRESS

3501 Fait Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/3/69

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 2 1969

25B. NAME OF REGISTRAR

John E. Wajer, M.D.

25C. FUNERAL DIRECTOR

John J. Wajer

ADDRESS

2829 Hudson St. Balto. Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

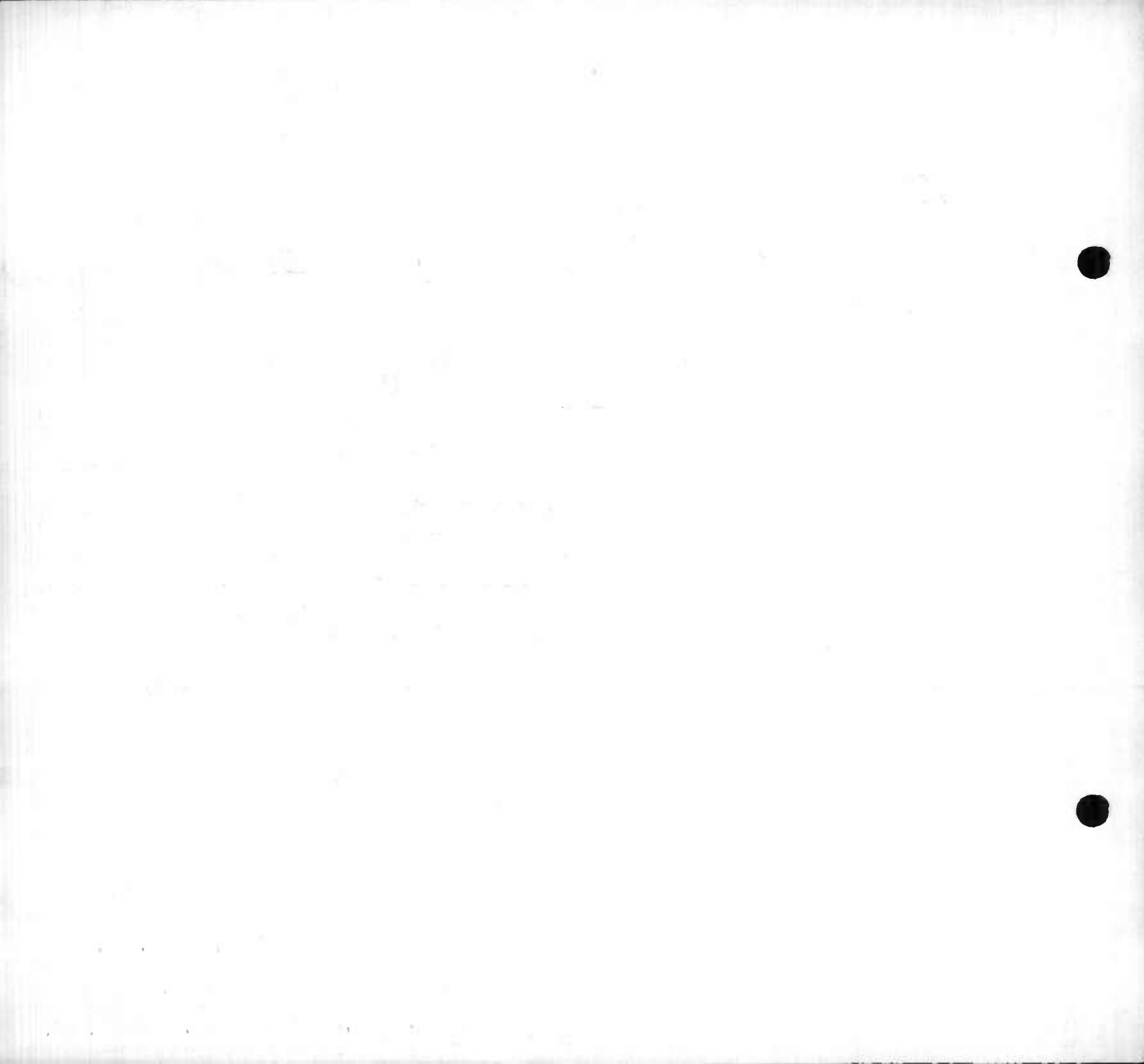
CERTIFICATE AMENDED - 7/7/69

7/7/69 - Correction form from funeral director.

JBC

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 6666
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Julia E. Caribo</u>		
2. DATE AND HOUR OF DEATH <u>6-29-69</u> <u>10:50 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>2421 Wythe Ave.</u> <u>21219</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		8. DATE OF BIRTH <u>June 10, 1918</u> 9. AGE (In years last birthday) <u>51</u>		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		
13. FATHER'S NAME <u>William Aston</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Margie Samuels</u>		
16. SOCIAL SECURITY NO. <u>456-16-9246</u>		17. INFORMANT (Husband) <u>Marvin Caribo</u> ADDRESS <u>Same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CEREBRAL EDEMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HRS</u>		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL HEMORRHAGE</u> <u>HRS</u>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>A. S. C. D.</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Diabetes Mellitus CEREBRO-VASCULAR DISEASE</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>DIABETES MELLITUS</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes (Telegraph)</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> 19 <u>69</u> to <u>6-29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6-29</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Delta Gomez-Dumaran, M.D.</u>		23B. DATE SIGNED <u>6/29/69</u>		
23C. PHYSICIAN'S NAME (Type) <u>Delta Gomez-Dumaran, M.D.</u>		23D. ADDRESS <u>Maryland General Hospital, Balto. Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/2/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park</u>
24D. LOCATION <u>Dorsey, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Lindsay</u> ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>



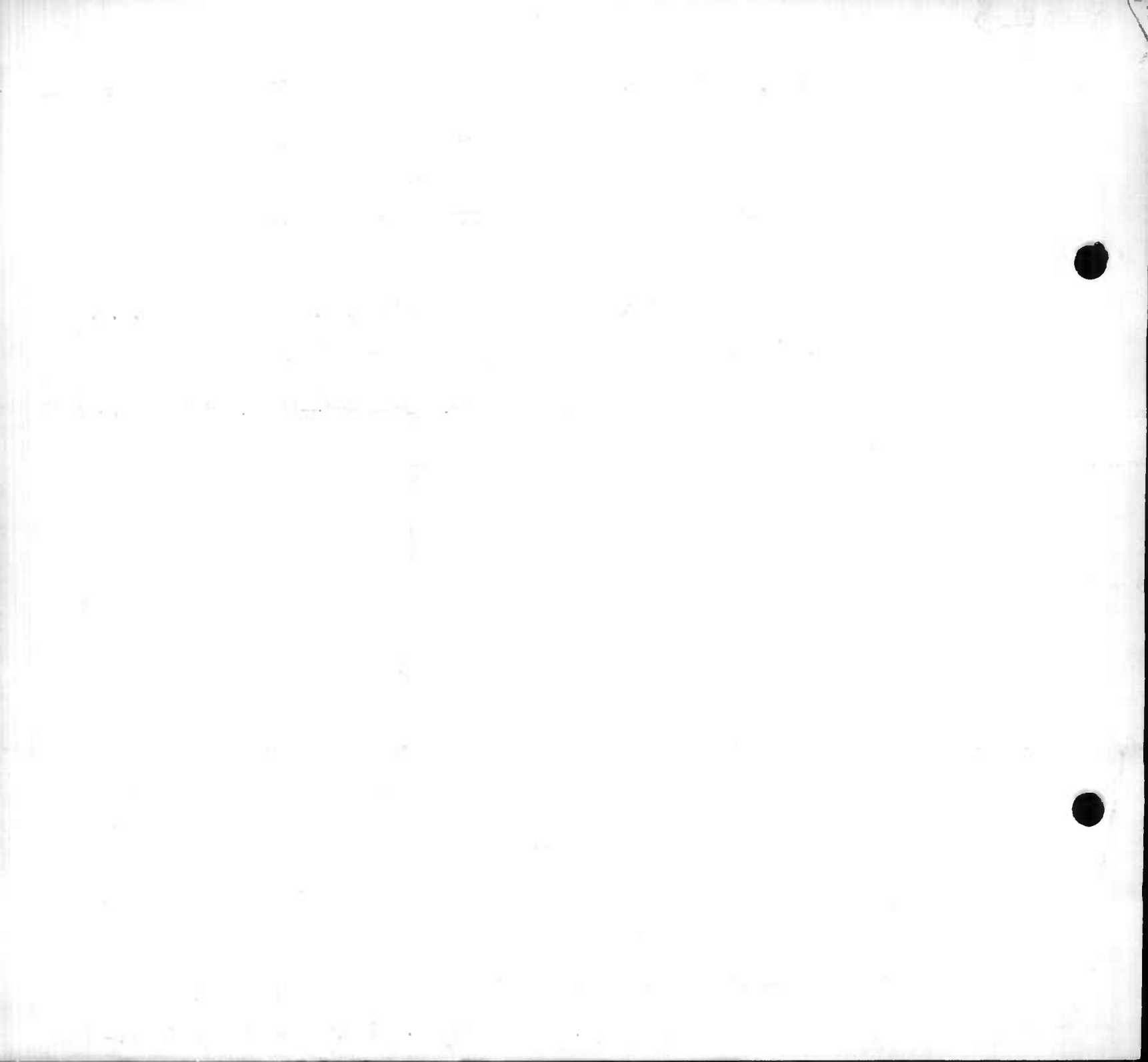
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6667 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

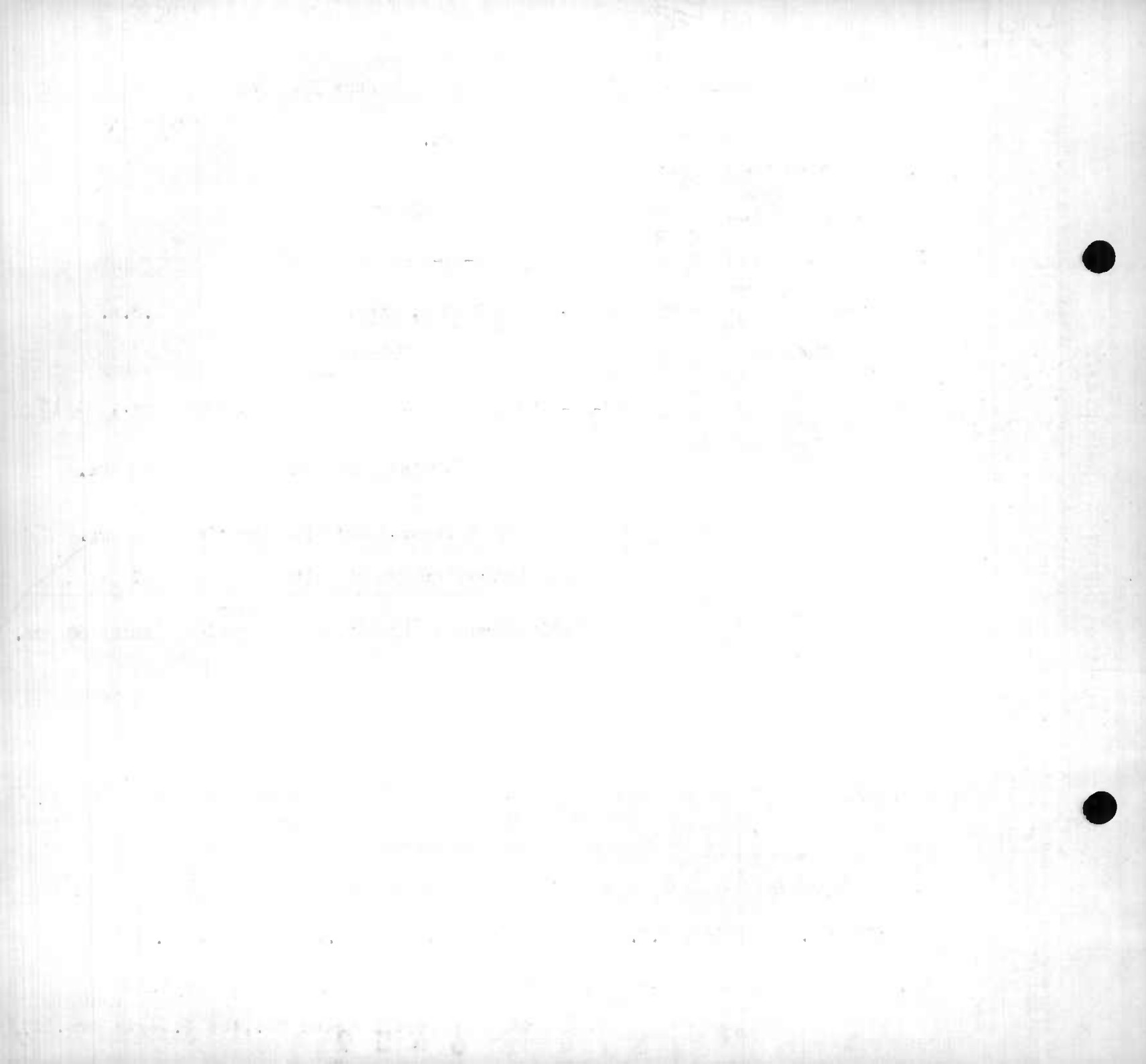
REG. NO. 69 6667

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BUNKE, William R.		2. DATE AND HOUR OF DEATH 6/30/69 11:40 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 534 N. Milton Avenue - (534)			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/3/21	9. AGE (in years last birthday) 47
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY Plumer		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Bunke		14. MOTHER'S MAIDEN NAME Maude Heiss	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 1111		17. INFORMANT Mrs. Maude Bunke ADDRESS 534 N. Milton Ave. - 21205	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 6/29/69 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that 69 (this hospital) attended the deceased from 6/29 19 69 to 6/30 19 69 that we last saw the deceased alive on 6/30 19 69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joel Engelstein, M.D.		23B. DATE SIGNED 6/30/69		23C. PHYSICIAN'S NAME (Type) Joel Engelstein, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-69		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR John E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John G. Miller, Inc.		25D. ADDRESS 6415 Belair Rd. - 21206			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Miss Lucy Caraffa		2. DATE AND HOUR OF DEATH June 30, 1969 5:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Mass. B. COUNTY V-18		C. CITY OR TOWN Boston	
FULL NAME OF HOSPITAL OR INSTITUTION The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> ? NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-27-91		9. AGE (In years last birthday) 78		If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Boston, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-7008		17. INFORMANT Records ADDRESS Seton Institute, 6400 Wabash Ave., 21215	
18. CAUSE OF DEATH I 410.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary & General Arteriosclerosis Cardiovascular Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 25 yrs. ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Schizophrenia, type Chronic Undifferentiated		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 60 yrs.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 17, 1961 to June 30, 1969 , that (I) (we) last saw the deceased alive on June 30, 1961 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter O. Jahrreiss, M.D.		23B. DATE SIGNED July 6, 1969		23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss, M.D.	
23D. ADDRESS 6400 Wabash Ave., Baltimore, Md. 21215		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/2/69		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR James E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co., 108 W. North Ave. (1)	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JOSEPH A. MUSIOL

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

June 28, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1227 Steelton Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 28, 1969

6:35 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2636

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10-18-1900

10. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1227 Steelton Avenue

11. BIRTHPLACE (State or foreign country)

Carnegie Pa

12. CITIZEN OF
WHAT COUNTRY?

? Musio

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Beth-Steel Co

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

232-07-9074

18. INFORMANT

ADDRESS

Wm Musiol 904 Chartress St Carnegie Pa

19. CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Pulmonary emboli

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-3-69

24C. NAME of CEMETERY or CREMATORY

St Joseph Cemetery

24D. LOCATION (City, town, or county)

Carnegie Pa

25A. DATE REC'D BY HEALTH DEPT.

JUL 2 1969

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

WALTER DABROWSKI 1005 DUNDALK AVENUE

ADDRESS

11.7 1000 7

11.7

11.7 1000 7

7-7

11.7 1000 7

11.7 1000 7

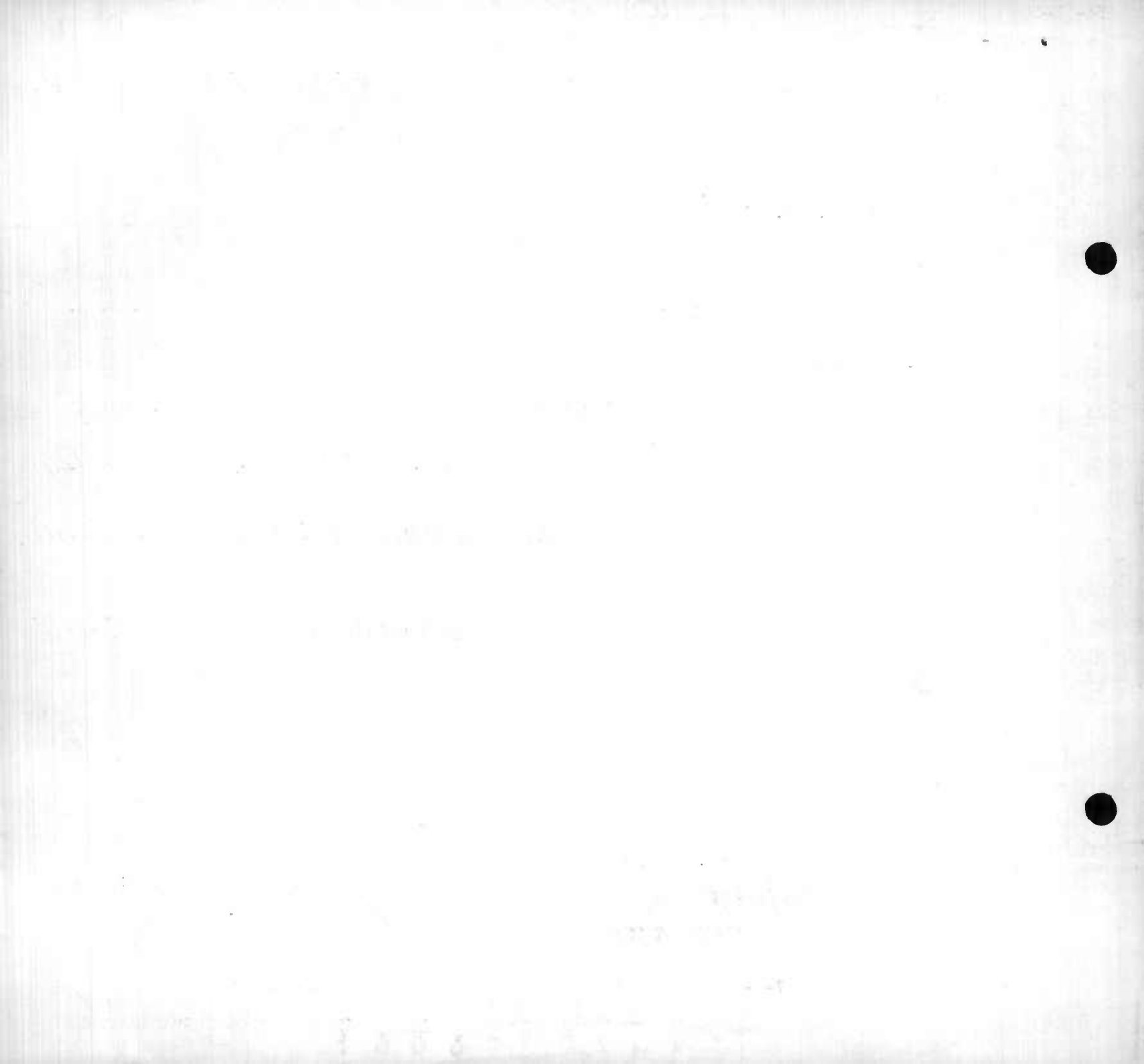
11.7 1000 7

7-7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6670	
BIRTH NO. 5320		69 6670		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Shaduk, Thomas		2. DATE AND HOUR OF DEATH 6/30/69 2 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY Baltimore	
31 Baltimore City Hospitals 4940 Eastern Ave. Balto. Md. 21224		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		6753 Roberts Avenue 21222			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Gibbs Packing Co		11. BIRTHPLACE (State or foreign country) Europe	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Shaduk			
14. MOTHER'S MAIDEN NAME Lenora Shaduk		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I			
16. SOCIAL SECURITY NO. 218-10-0101A		17. INFORMANT BCH Records: 4940 Eastern Ave. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Broncho pneumonia 7 days			
ANTECEDENT CAUSES		(B) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 yrs			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) COCHEXIA 2 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/29 19 69 to 6/30 19 69, that (I) (we) lost saw the deceased alive on 6/30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 6/30/69		23C. PHYSICIAN'S NAME (Type) R. M. Moore	
23D. ADDRESS 4940 Eastern Ave. 21224		23E. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-1969		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 2 1969			
24F. NAME OF REGISTRAR Robert E. Taylor, M.D.		24G. ADDRESS 1005 DUNDALK AVENUE			



FUNERAL DIRECTOR: IMPORTANT

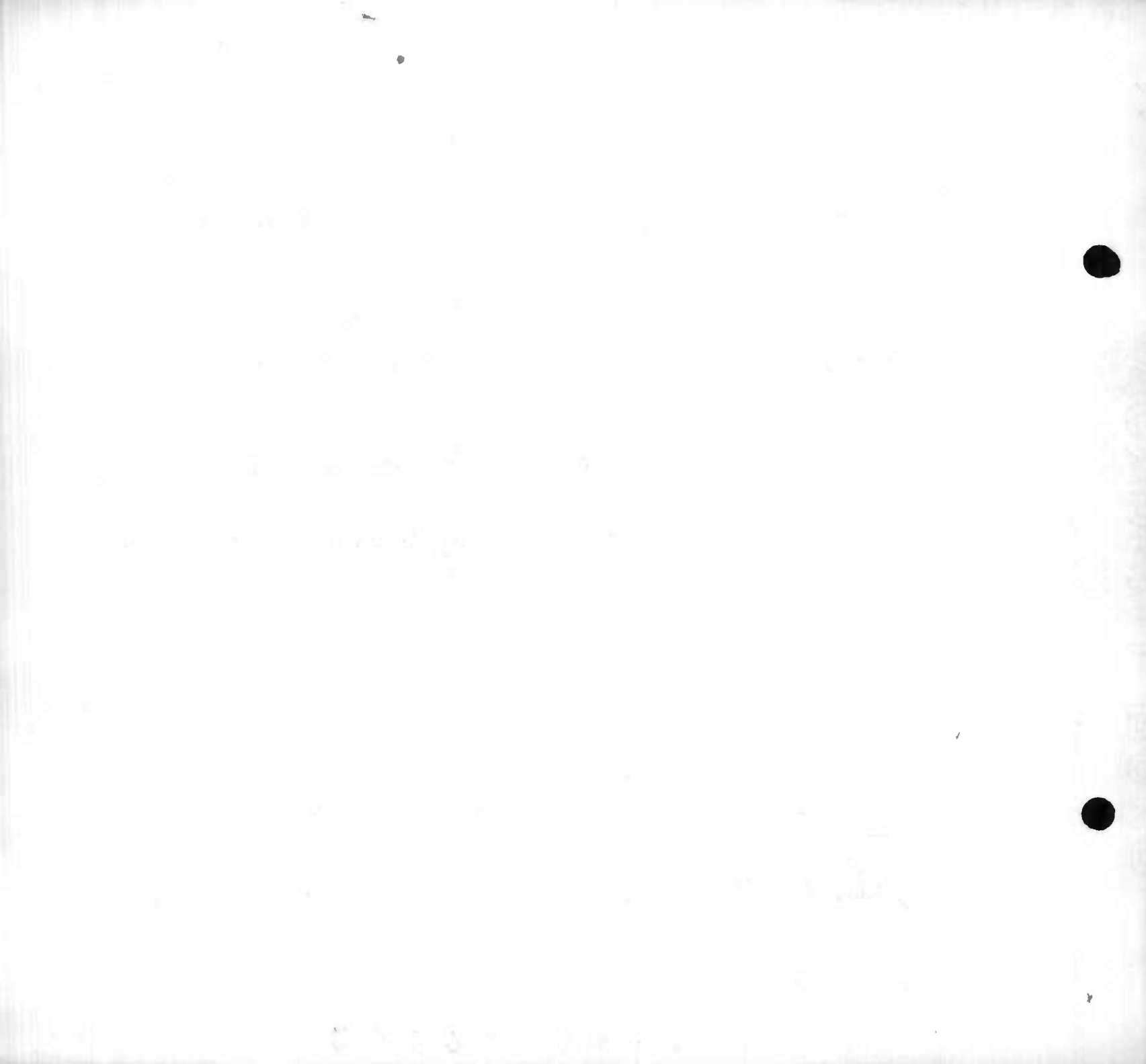
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6671	
69 6671				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Osbourne Grace A.</i>				6/27/69 11:20 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>House In The Pines 5837 Belair Rd. Balto., Md. 21206</i>				A. STATE <i>Md.</i> B. COUNTY <i>Balto. Co.</i> 53-00	
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4321 Belmar Avenue 21206</i>					
5. SEX <i>M.</i>	6. RACE <i>Cau</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/12/1885</i>	9. AGE (In years last birthday) <i>84</i>	10. AGE (In years last birthday) <i>84</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William R. Hilburg</i>			
14. MOTHER'S MAIDEN NAME <i>Lillian Rawling</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>212-34-9439</i>		17. INFORMANT ADDRESS <i>George E. Osbourne 4312 Belmar Ave. 212</i>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Uremia</i>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Uremia</i> 7-10 days					
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure</i> 20 days					
(C) <i>Acute Myocardial Infarction</i> 16 days					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Hypertension, Chronic G. U. Infection, Arteriosclerosis, Cardiac Arrhythmia</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/1/69</i> 19 <i>69</i> to <i>6/27</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6/23</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bentley</i>				23B. DATE SIGNED <i>6/22/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Albert B. Bentley</i>				23D. ADDRESS <i>600 E. Baltimore St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-30-1969</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1969</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Lasahn Funeral Home 7401 Belair Rd. 21234</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

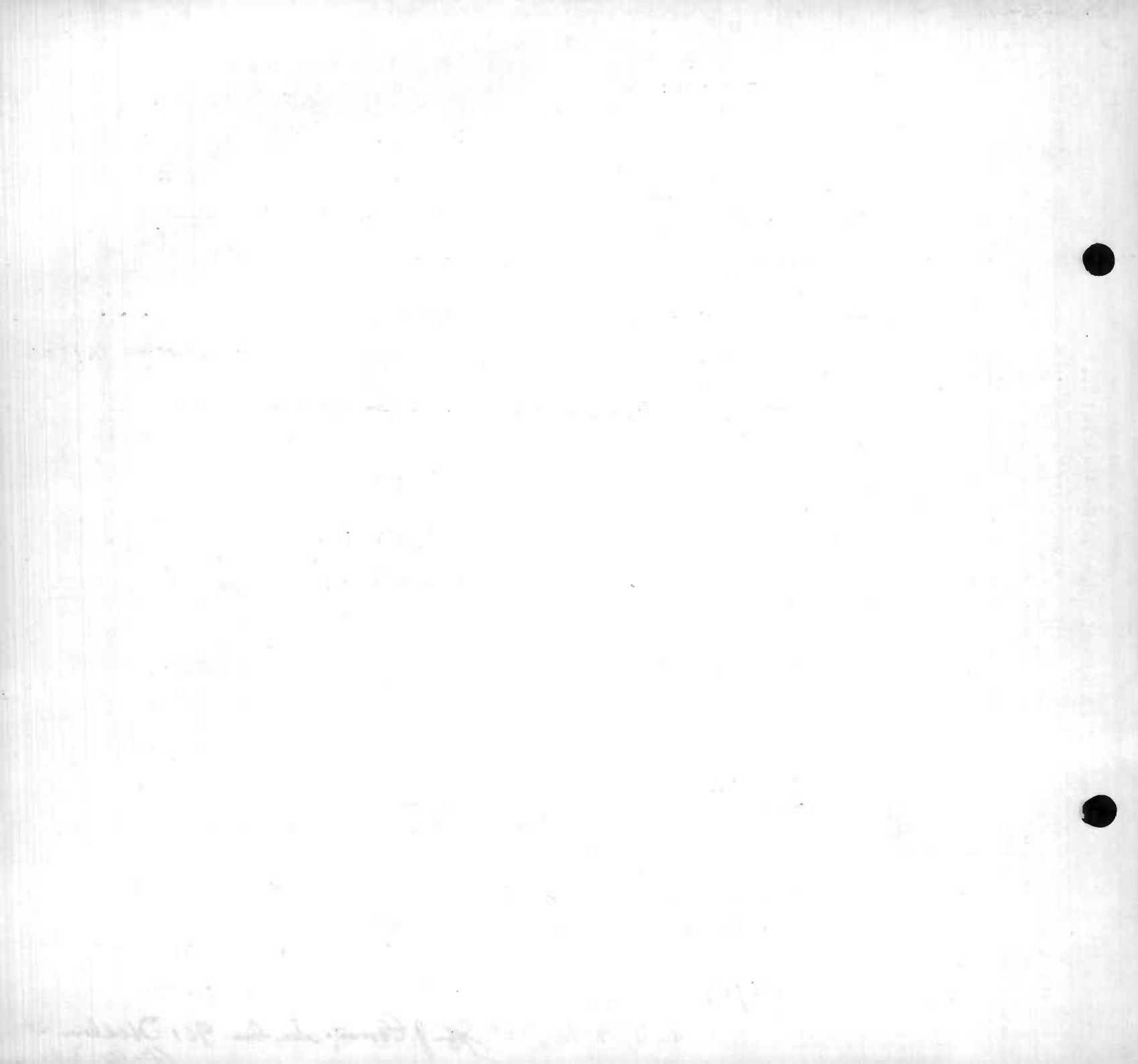
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 6672		69 6672		69 6672	
<div> <div>1. NAME OF DECEASED (Type or Print)</div> <div>WILLIAM HENRY HYSON (Hynson)</div> </div> <div> <div>2. DATE AND HOUR OF DEATH</div> <div>7-1-69 9:05 A.M.</div> </div>					
<div>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> <div>SOUTH BALTIMORE GEN. HOSP. 3001 S. HANOVER</div>			<div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div>MARYLAND BALTO 2302</div>		
<div>5. SEX</div> <div>M</div>			<div>6. RACE</div> <div>CAUC</div>		
<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>			<div>8. DATE OF BIRTH</div> <div>12-13-10</div>		
<div>9. AGE (In years last birthday)</div> <div>58</div>			<div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>LABORER</div>		
<div>11. BIRTHPLACE (State or foreign country)</div> <div>BALTO, MD</div>			<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>		
<div>13. FATHER'S NAME</div> <div>THOMAS</div>			<div>14. MOTHER'S MAIDEN NAME</div> <div>FLORENCE BOOTH</div>		
<div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>NO</div>			<div>16. SOCIAL SECURITY NO.</div>		
<div>17. INFORMANT</div> <div>Family - Jance</div>			<div>ADDRESS</div>		
<div>18. CAUSE OF DEATH</div> <div>4109 I</div> <div>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>Profound Cardiovascular Collapse</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div>Acute Myocardial Infarction</div> <div>ASCVD</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>MINS</div> <div>HRS</div> <div>YEARS</div>					
<div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</div>					
<div>19A. DATE OF OPERATION</div> <div>0</div>		<div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div>20A. AUTOPSY? (Yes or No)</div>	
<div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div>		<div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>		<div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div>	
<div>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</div>		<div>21E. INJURY OCCURRED</div> <div>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>		<div>21F. HOW DID INJURY OCCUR?</div>	
<div>22. I certify that (I) (this hospital) attended the deceased from 6-25 19 69 to 7-1 19 69</div> <div>that (I) (we) last saw the deceased alive on 7-1 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
<div>23A. SIGNATURE</div> <div>Arnold M. Wood, MD</div>				<div>23B. DATE SIGNED</div> <div>7-1-69</div>	
<div>23C. PHYSICIAN'S NAME (Type)</div>				<div>23D. ADDRESS</div>	
<div>24A. BURIAL, CREMATION, REMOVAL (Specify)</div>		<div>24B. DATE</div> <div>7-5-69</div>		<div>24C. NAME OF CEMETERY OR CREMATORY</div> <div>Edgar & Sons</div>	
<div>24D. LOCATION (City, town, or county)</div> <div>Baltimore</div>		<div>24E. DATE REC'D BY HEALTH DEPT.</div> <div>JUL 2 1969</div>		<div>24F. NAME OF REGISTRAR</div> <div>Robert E. Tolbert, M.D.</div>	
<div>24G. FUNERAL DIRECTOR</div> <div>6665 - 130 E. Fort Ave.</div>		<div>24H. ADDRESS</div>		<div>24I. SIGNATURE</div>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-460		69 6673		69 6673	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LILLIAN MILLER		6/30/69 4:55 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		2646	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1403 Rayleigh Way		21224	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	10-30-1906	62	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cashed		Candy Co.		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Gear		Florence Raynter PAYTON		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-18-8414		Records: BCH-4940 Eastern Avenue 21224	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis paritonitis carcinoma, duodenum			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes	YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
6-23-69					
22. I certify that (I) (this hospital) attended the deceased from 6/26 1969 to 6/30 1969, that (I) (we) last saw the deceased alive on 6/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. Case		6/24/69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
David B. Case, M.D.		Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	7/3/69	Oak Lawn Cemetery		Baltimore Co. Ind.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1969		Robert E. Galt, M.D.		John J. Gwalt, M.D. Inc. 901 Hollins St. Baltimore, Ind.	



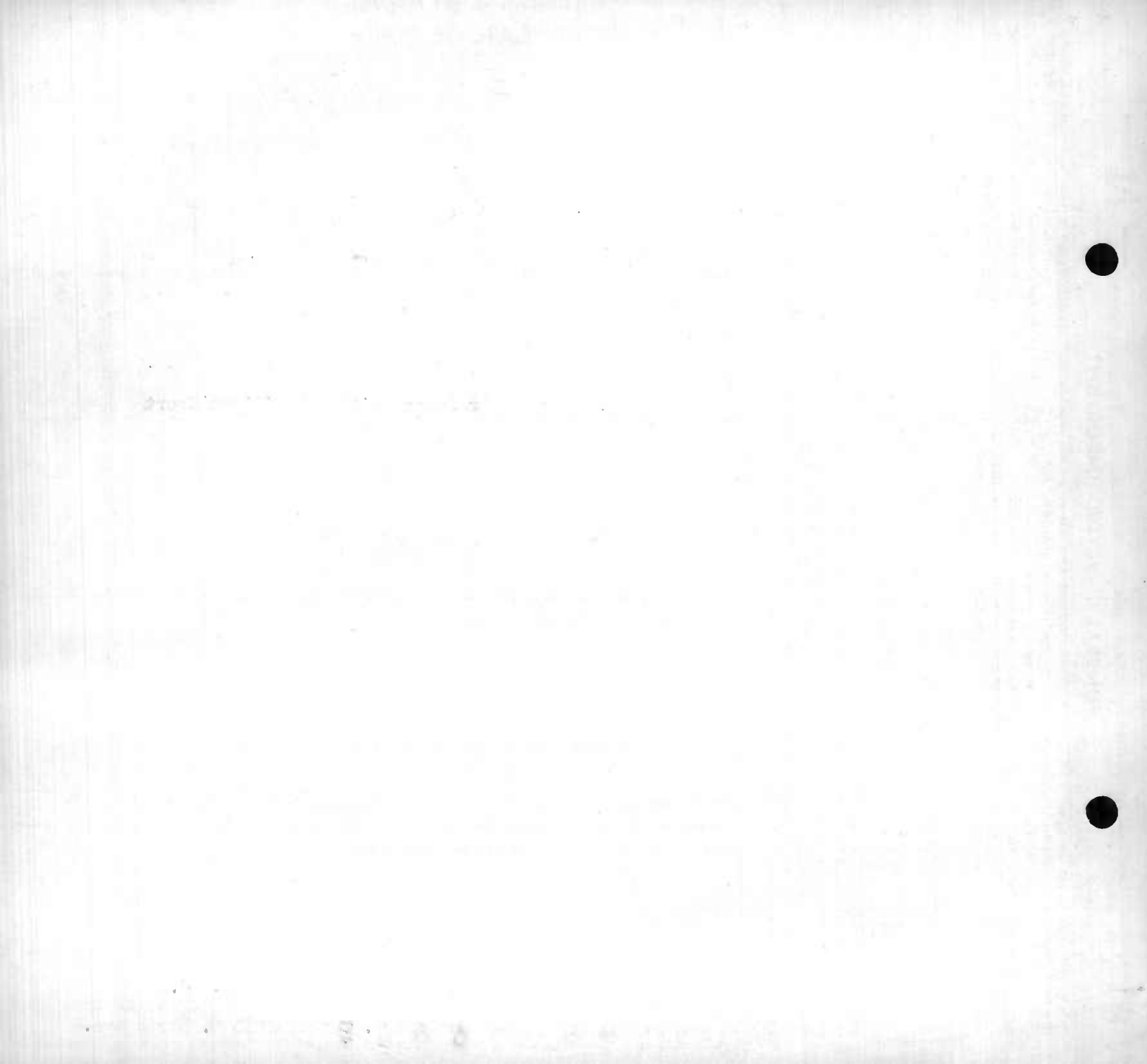
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6674 CERTIFICATE OF DEATH

REG. NO. 69 6674

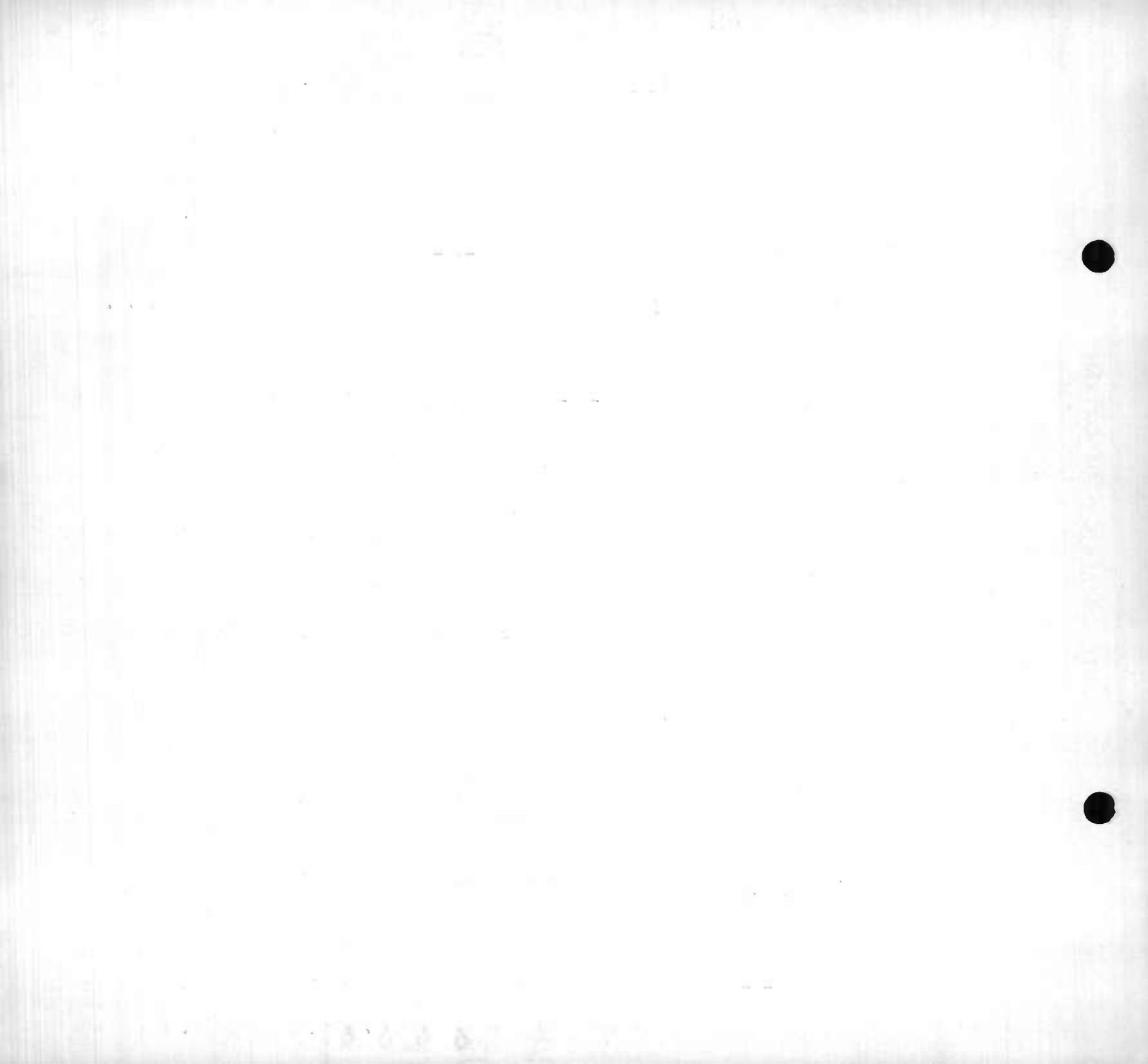
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Richardson, Mary E</i>		2. DATE AND HOUR OF DEATH <i>6/26/69 9:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>PARK Hill Nursing Home</i>		C. CITY OR TOWN <i>BALTO.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>		8. DATE OF BIRTH <i>10-30-'84</i>	
13. FATHER'S NAME <i>David Smith</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Emma Jackson</i>		9. AGE (In years last birthday) <i>84</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213365453</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
18. <i>707.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CHF</i> (B) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
17. INFORMANT <i>Mr James Smith</i>		ADDRESS <i>827 Hillman Court</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2d</i>	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>6</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>29 May 1969</i> to <i>26 Jun 1969</i> , that (I) (we) last saw the deceased alive on <i>26 Jun 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jaroslav Hulla</i>		23B. DATE SIGNED <i>26 Jun 69</i>		23C. PHYSICIAN'S NAME (Type) <i>Jaroslav Hulla</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/30/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Gutter</i>		25C. FUNERAL DIRECTOR <i>Herbert E. Gutter</i>	
24D. LOCATION <i>Baltimore CO. Md.</i>		24E. ADDRESS <i>3035 W. North Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6675	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frances Stephens		2. DATE AND HOUR OF DEATH 6/30/69 11:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1510			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital Balto.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4012 Maine Ave					
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-80	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ? ?		14. MOTHER'S MAIDEN NAME ? ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-30-5268		17. INFORMANT Mrs Lena Henley 3053 Brighton Street	
18. 486 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypokalemia + Acidosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia + dehydration		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral + Coronary ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? hrs ? days ? years	
MEDICAL CERTIFICATION					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cerebral + Coronary ASCVD					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/30 1969 to 6/30 1969 , that (1) (we) last saw the deceased alive on 6/30 1969 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanford H. Molinar MD				23B. DATE SIGNED 6/30/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS SINAI Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Nutter		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

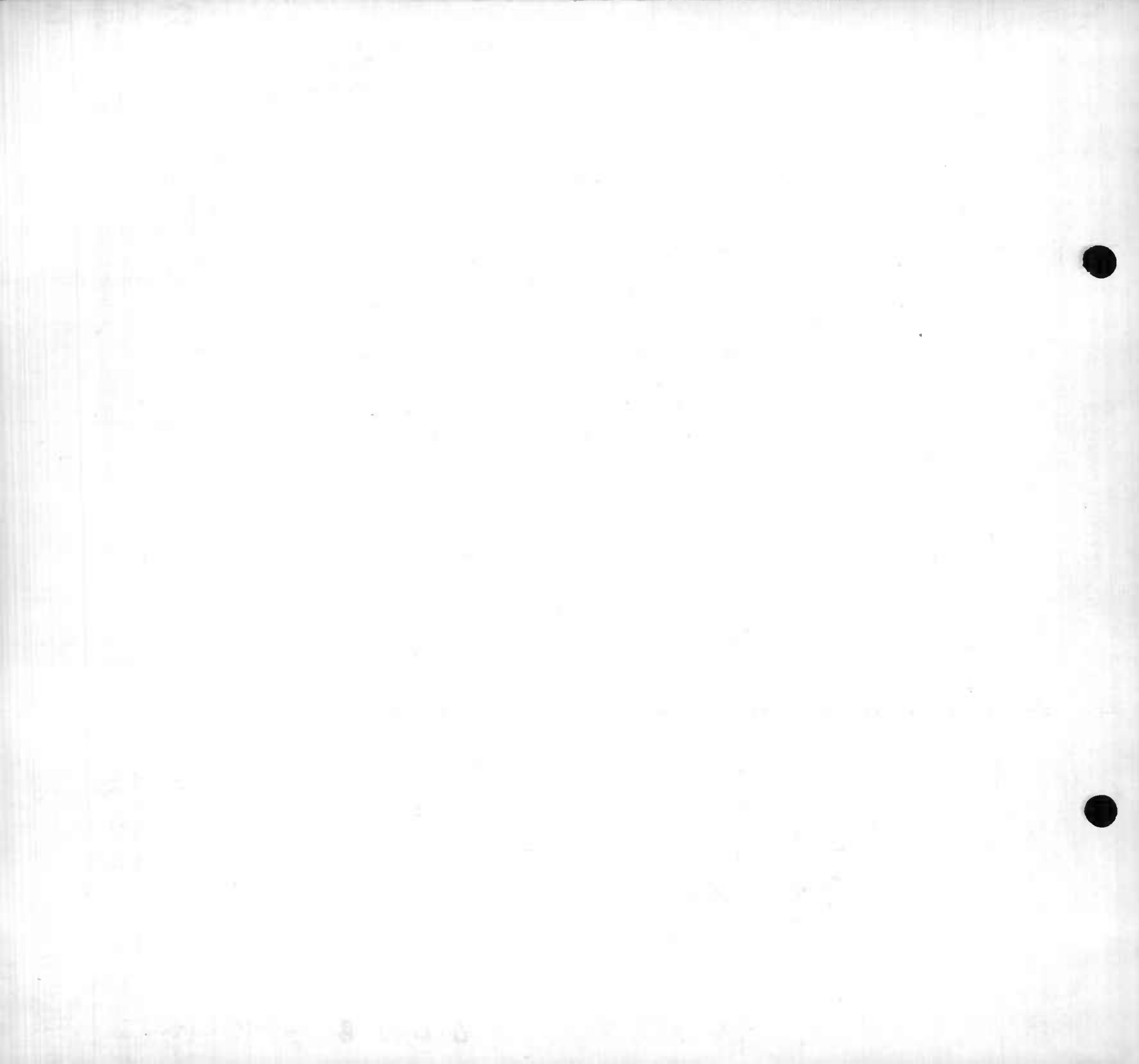
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6676	
69 6676 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Edna Marie Connors</u>		2. DATE AND HOUR OF DEATH <u>June 29, 1969 2:20 a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2733</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4008 Moravia Rd.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/04/15</u>	9. AGE (In years last birthday) <u>54</u>	10. Under 1 Yr. If Under 24 Hrs. Min. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>HENRY HOFFMAN</u>		
14. MOTHER'S MAIDEN NAME <u>DORA KRAUSZ</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>ALOYSIUS P CONNORS- 4008 MORAVIA</u>		
18. <u>5719 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cirrhosis of Liver</u> (B) <u>Cholera</u> (C) <u>Y S</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 26</u> 19 <u>69</u> to <u>June 29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>June 29</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles R. Goshen</u> M.D. DEGREE				23B. DATE SIGNED <u>6/29/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR CHARLES GOSHEN</u>				23D. ADDRESS <u>THE UNION MEMOTIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/2/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	
24D. LOCATION <u>BROOKLYN</u>		24E. (City, town, or county)		24F. (State) <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>UNION MEMOTIAL HOME 4010 BELAIR</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6677	
BIRTH NO.		69 6677		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CHARLES W. SMITH			JUNE 27, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 129 S. COLLINS AVE.			A. STATE MD.		B. COUNTY 2008
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 129 S. COLLINS AVE.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 7, 1910	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN		10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN L. SMITH		
14. MOTHER'S MAIDEN NAME ANNE C. LOWERY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 213-12-2192			17. INFORMANT Mrs Charles W. Smith-129 S. Collins Ave		
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Circumstances of lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) this hospital attended the deceased from May 19 69 to 6/27 19 69, that (I) we last saw the deceased alive on 6/20 19 69 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE James Nolan MD			23B. DATE SIGNED 6/28/69		23C. PHYSICIAN'S NAME (Type) J J NOLAN
23D. ADDRESS Baltimore Md 21229			23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 6-30-69	24C. NAME of CEMETERY or CREMATORY Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969	25B. NAME OF REGISTRAR L. E. Garber, M.D.		25C. FUNERAL DIRECTOR F. B. Garber, M.D.		
25D. ADDRESS			25E. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

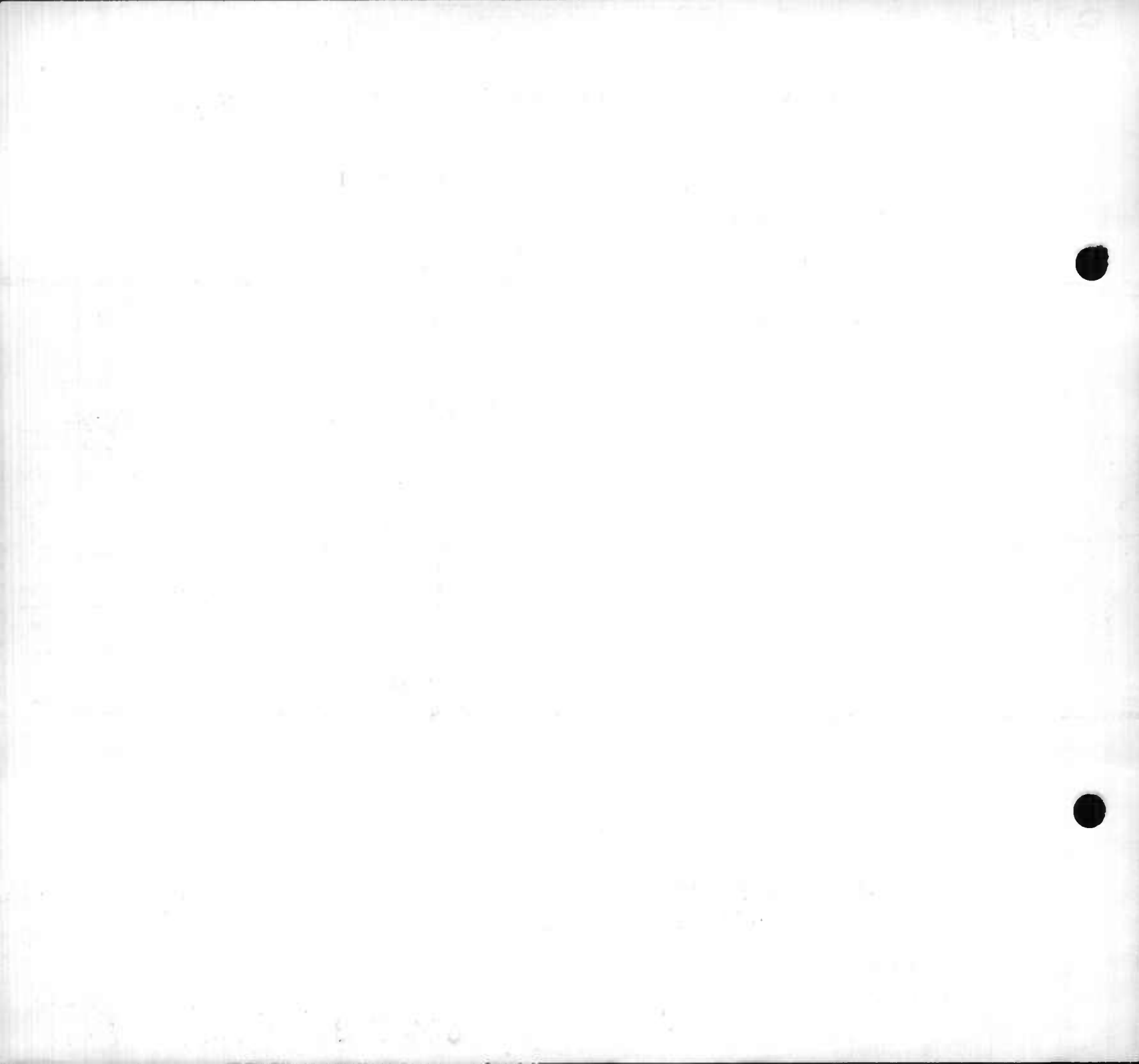
Baltimore City Health Department				REG. NO.	
BIRTH NO.		69 6678		69 6678	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
DELMA E. ELLIS		6-25-69, 8:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
37 MERCY HOSPITAL		MARYLAND		2403	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1213 LIGHT ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-17-96	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GRANVILLE MYERS		MARY JANE WISE			
15. Was Deceased Ever In U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Margaret Ellis 1811 W. ...	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
433901 250.9		ACUTE CEREBRAL INFARCTION			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ACUTE CEREBROVASCULAR OCCLUSION			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		ATHEROSCLEROTIC VASC. DISEASE			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DIABETES MELLITUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6-25-1969 to 6-25-1969 that (X) (we) last saw the deceased alive on 6-25-1969 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph Notarangelo M.D.				JUNE 26-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH NOTARANGELO M.D.				MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-30-69		Baltimore ...	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1969		Joseph E. ...		John ...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6679		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6679	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lawrence T. Berliner</u>		2. DATE AND HOUR OF DEATH <u>June 29 4:00 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Florida</u> B. COUNTY <u>Miami</u>		M. <u>V-08</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>33 601 N. Broadway</u>		C. CITY OR TOWN <u>MIAMI</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12-24-81</u>		9. AGE (In years last birthday) <u>87 yrs</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fla</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>M. M. J. Berliner</u>	
18. <u>189.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Azotemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months at least</u>	
(B) <u>Carcinomatosis - Kidney</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>Caecum</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/9</u> 19 <u>69</u> to <u>6/29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. Semerdjian</u>				23B. DATE SIGNED <u>6/29/69 4:00 PM</u>	
23C. PHYSICIAN'S NAME (Type) <u>Grant Semerdjian MD</u>		23D. ADDRESS <u>601 N. Broadway Balto MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7/3/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Conroy Jewish Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Conroy Pa</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>		25B. NAME OF REGISTRAR <u>Wm. E. Talbot, MD</u>		25C. FUNERAL DIRECTOR <u>Wm. E. Talbot, MD</u>	
ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6680 CERTIFICATE OF DEATH

REG. NO. 69 6680

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMESON F. PIKE		2. DATE AND HOUR OF DEATH 7-1-69 6:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Balto Md B. COUNTY 21209 2730		C. CITY OR TOWN 12 St D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
FULL NAME OF HOSPITAL OR INSTITUTION PLEASANT MANOR NURSING HOME		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 70		E. STREET AND NUMBER 6310 Greenspring Ave	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-85	9. AGE in years (last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D.C	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry		14. MOTHER'S MAIDEN NAME Lulu	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-69-2997		17. INFORMANT Mrs Josie Pike ADDRESS Same	
18. 142.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal - Partial Head Carcinoma Left		5/1/68	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Myocardial Heart Disease DUE TO, OR AS A CONSEQUENCE OF:		1/10/55	
		(C) Coronary Heart Failure		6/29/69	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Primary Hypopharyngeal Carcinoma, Right		11/22/68	
19A. DATE OF OPERATION 4/10/69	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Partial Head Carcinoma, Left	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/6/39 19 to 7/1/69 19, that (I) <u>we</u> lost saw the deceased alive on 7/1/69 19 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE A. William Primakoff, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/1/69	
23C. PHYSICIAN'S NAME (Type) A. WILLIAM PRIMAKOFF, M.D.		23D. ADDRESS Emersonian Apartments - Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 7/2/69	24C. NAME OF CEMETERY or CREMATORY Landon Park		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR James E. Barber, M.D.		25C. FUNERAL DIRECTOR William Lewis & Son ADDRESS S.D.C	

220

200

210

220

230

240

James - 1000

James - 1000

James - 1000

James - 1000

James - 1000

James - 1000

250

260

270

280

290

James - 1000

James - 1000

James - 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6681 CERTIFICATE OF DEATH

REG. NO.

69 6681

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mrs. Estelle L. Wells

2. DATE AND HOUR OF DEATH

June 29, 1969

5:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Long Green Nursing Home

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4407 Marble Hall Road

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1/19/1878

9. AGE (In years lost birthday)

91

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edwin W. King

14. MOTHER'S MAIDEN NAME

Elizabeth L. Bishop

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Marion S. King - 4407 Marble Hall Rd.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Carcinoma of Lung

1 1/2 yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/30/45 19 to 6/29/69 19, that (I) (we) last saw the deceased alive on 6/28/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Francis W. Gluck MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

6/30/69

23C. PHYSICIAN'S NAME (Type)

Francis W. Gluck

DEGREE

23D. ADDRESS

100 W. University Pkw.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/2/69

24C. NAME OF CEMETERY or CREMATORY

Greenmount Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 2 1969

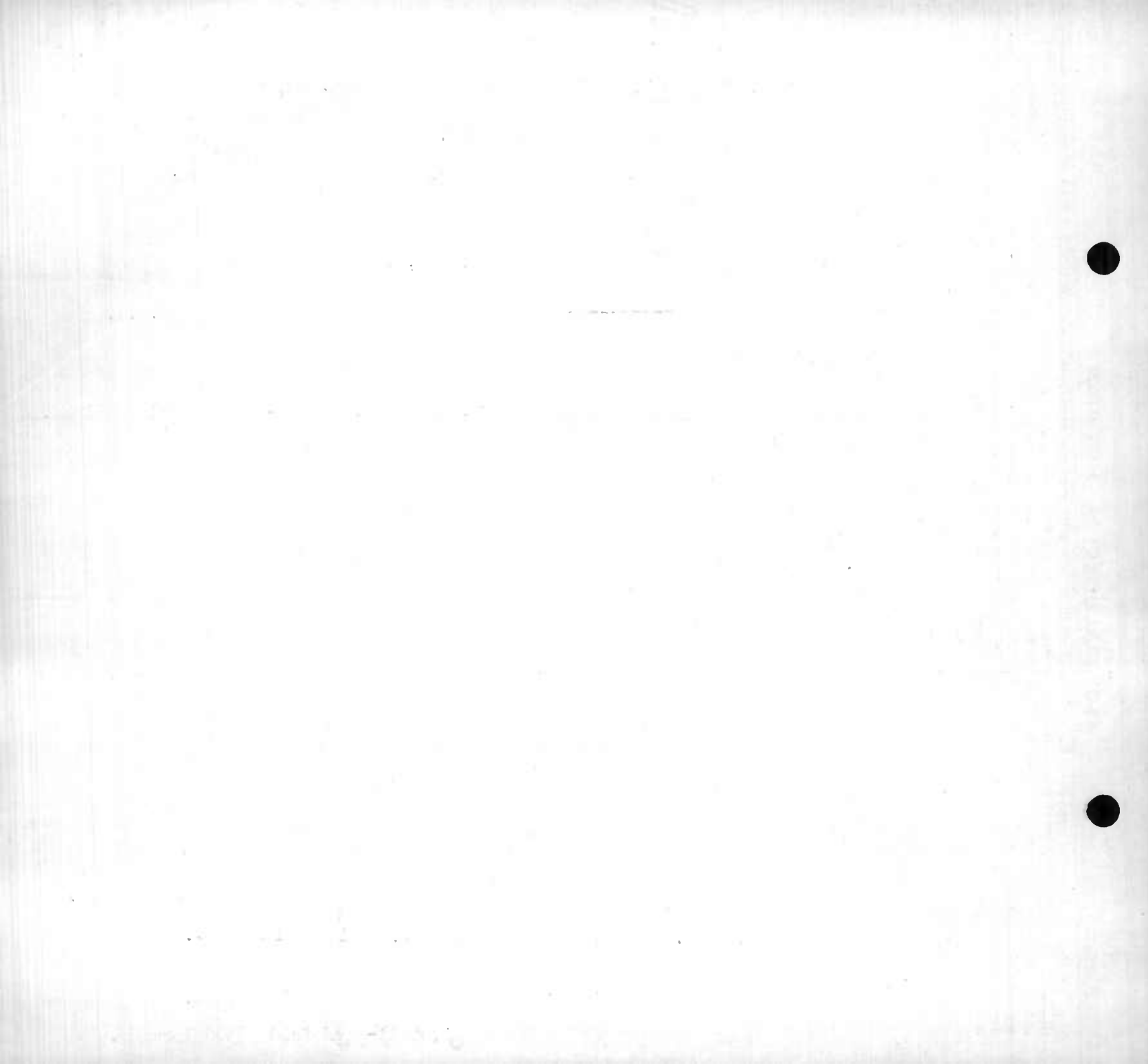
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Mitchell-Wiedefeld 6500 York Rd.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-200		69 6682		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6682	
1. NAME OF DECEASED (Type or Print) Asch, Jesse J.				2. DATE AND HOUR OF DEATH 6/29/69 10¹⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8908 Maplebrook Rd			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16	9. AGE (In years lost birthday) 53 yrs	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN ASCH				14. MOTHER'S MAIDEN NAME KATHERINE OPPEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 8908 MAPLEBROOK ROAD MRS. DORA ASCH, RANDALLSTOWN, MD. 21133			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary artery Disease (C) severe				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1946 19 to 6/29 19 69 , that (I) (we) last saw the deceased alive on 6/28 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edward S. Hallins DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/29/69	
23C. PHYSICIAN'S NAME (Type) E. S. HALLINS MD DEGREE				23D. ADDRESS 6000 PARK HTS RD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-1-69		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH-BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR ADDRESS 901 LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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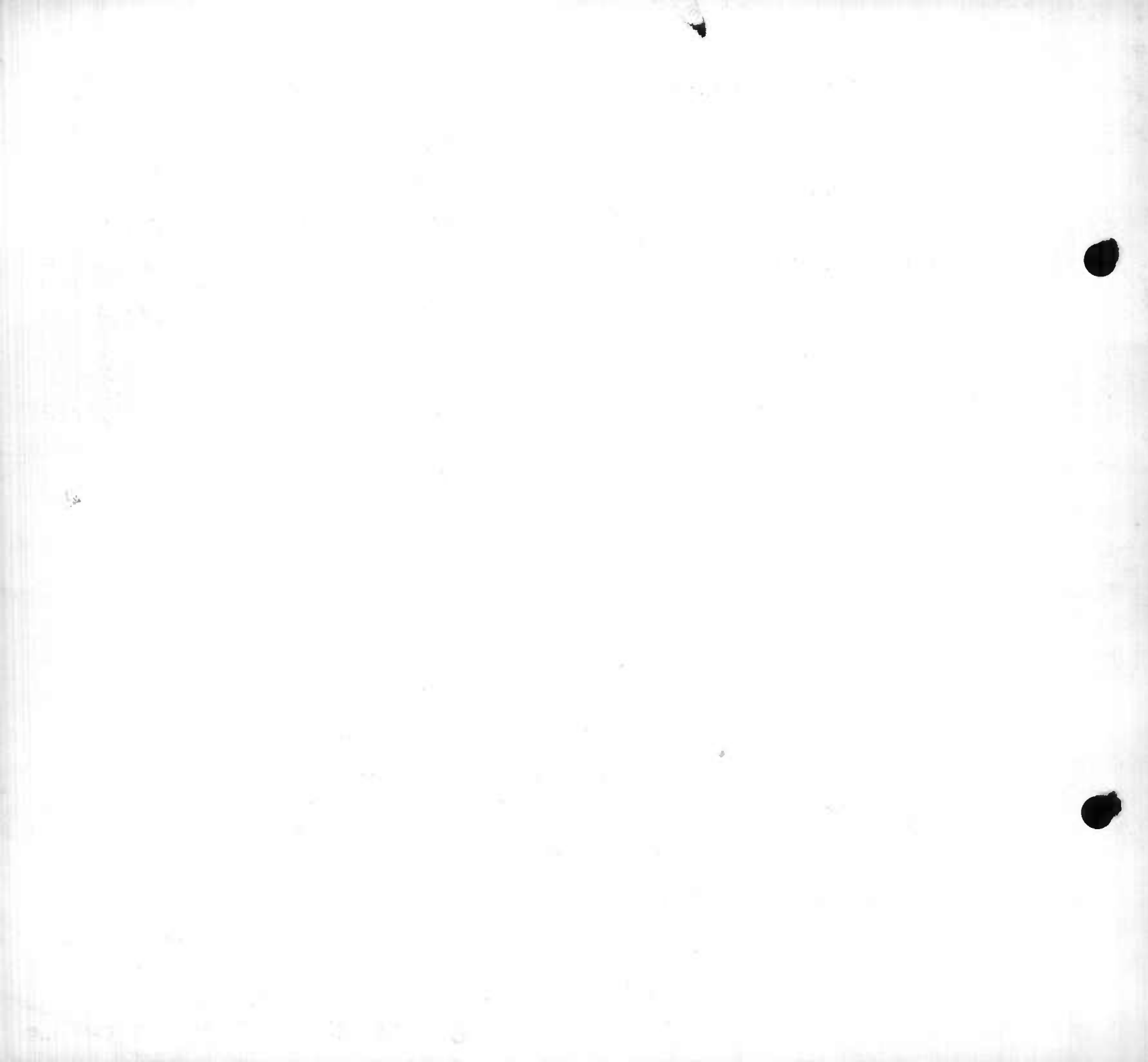
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6683</u>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GROSS, LEROY</u>		2. DATE AND HOUR OF DEATH <u>6-30-69</u> <u>1 25 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY Hospital</u>			A. STATE <u>MD</u> B. COUNTY <u>1601</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>NEGRO</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>913 BENNETT AVE</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH <u>7-2-90</u>		9. AGE (in years last birthday) <u>78</u>
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>WIFE - EDNA</u>
18. <u>4/10/9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>6-30</u> 19 <u>69</u> to <u>6-30</u> 19 <u>69</u> that <u>X</u> (we) last saw the deceased alive on <u>D.O.A.</u> 19 <u> </u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>C. S. DeFelice</u>				23B. DATE SIGNED <u>6-30-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. E. DeFelice</u>				23D. ADDRESS <u>UNIVERSITY Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/3/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	
24D. LOCATION <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>			
25B. NAME OF REGISTRAR <u>John E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>Agolpus Halstead</u>			
25D. ADDRESS <u>1206 W north A.</u>					



FUNERAL DIRECTOR: IMPORTANT

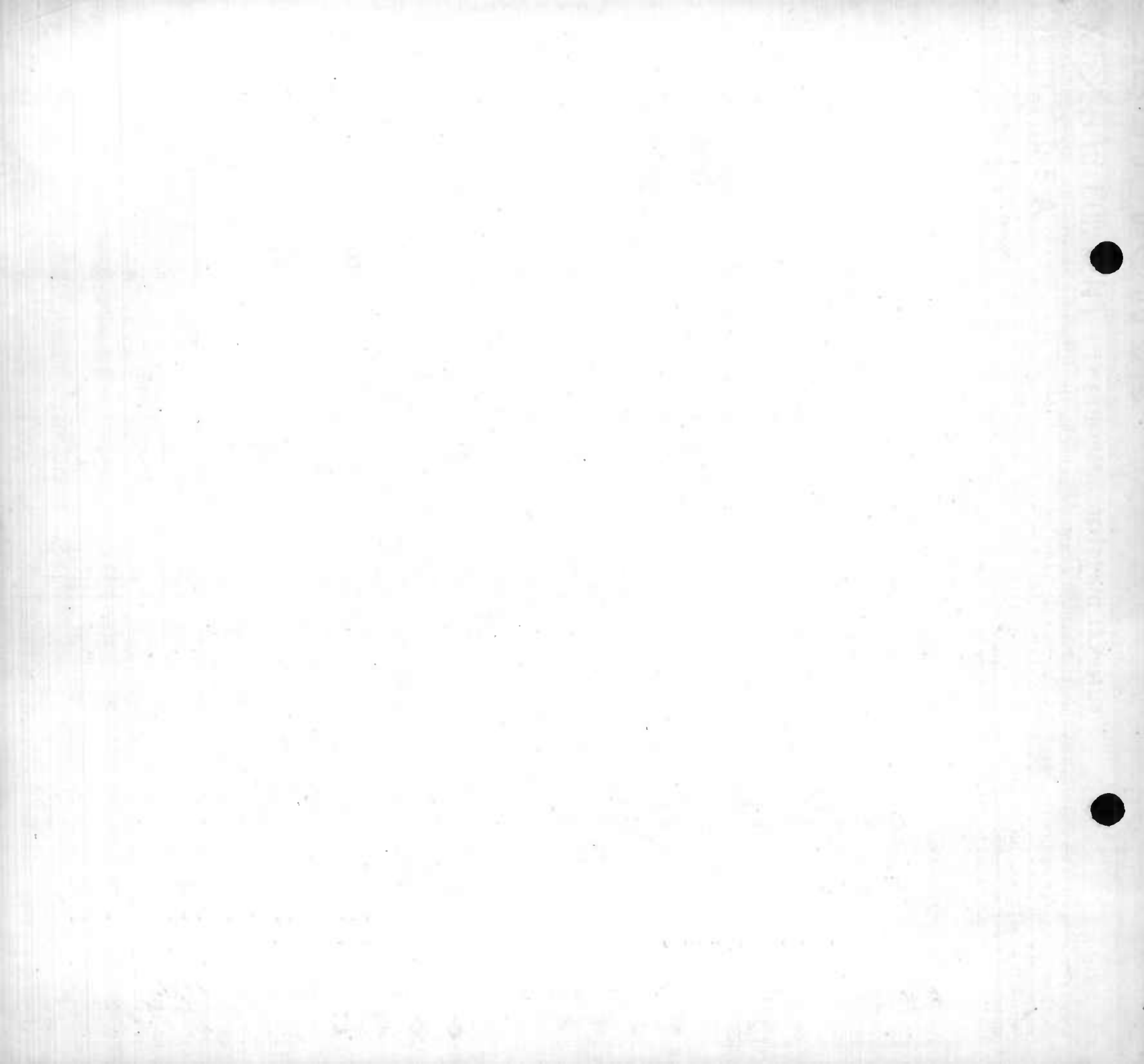
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 6684 CERTIFICATE OF DEATH

REG. NO. 69 6684

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John Wesley Coombs</i>		2. DATE AND HOUR OF DEATH <i>6-28-69</i> <i>6 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1504</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington NURS. Home.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i>		6. RACE <i>non white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Freight car writer</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>8-6-1878</i> 9. AGE (In years lost birthday) <i>90</i>	
11. BIRTHPLACE (State or foreign country) <i>Charles Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Coombs</i>	
14. MOTHER'S MAIDEN NAME <i>MARtha Stone</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-03-5127-8</i>	
17. INFORMANT <i>CHART #873</i>		ADDRESS <i>607 Penn Ave</i>		18. <i>413.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>ARTERIOSCLEROTIC HEART DISEASE</i> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>GENERALIZED ARTERIOSCLEROSIS years</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>YEARS</i>		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Congestive Heart Failure</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>12 MAY 1969</i> to <i>28 JUNE 1969</i> , that (2) (we) last saw the deceased alive on <i>28 JUNE 1969</i> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard Tyson</i>		23B. DATE SIGNED <i>6-28-69</i>		23C. PHYSICIAN'S NAME (Type) <i>Richard Tyson, MD</i>	
23D. ADDRESS <i>Baltimore, Maryland 21217</i>		23E. HOW DID INJURY OCCUR?			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7-2-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. AUBURN CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1969</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Kelson F. H.</i>			
25D. ADDRESS <i>1748 N. Calhoun ST</i>					



FUNERAL DIRECTOR: IMPORTANT

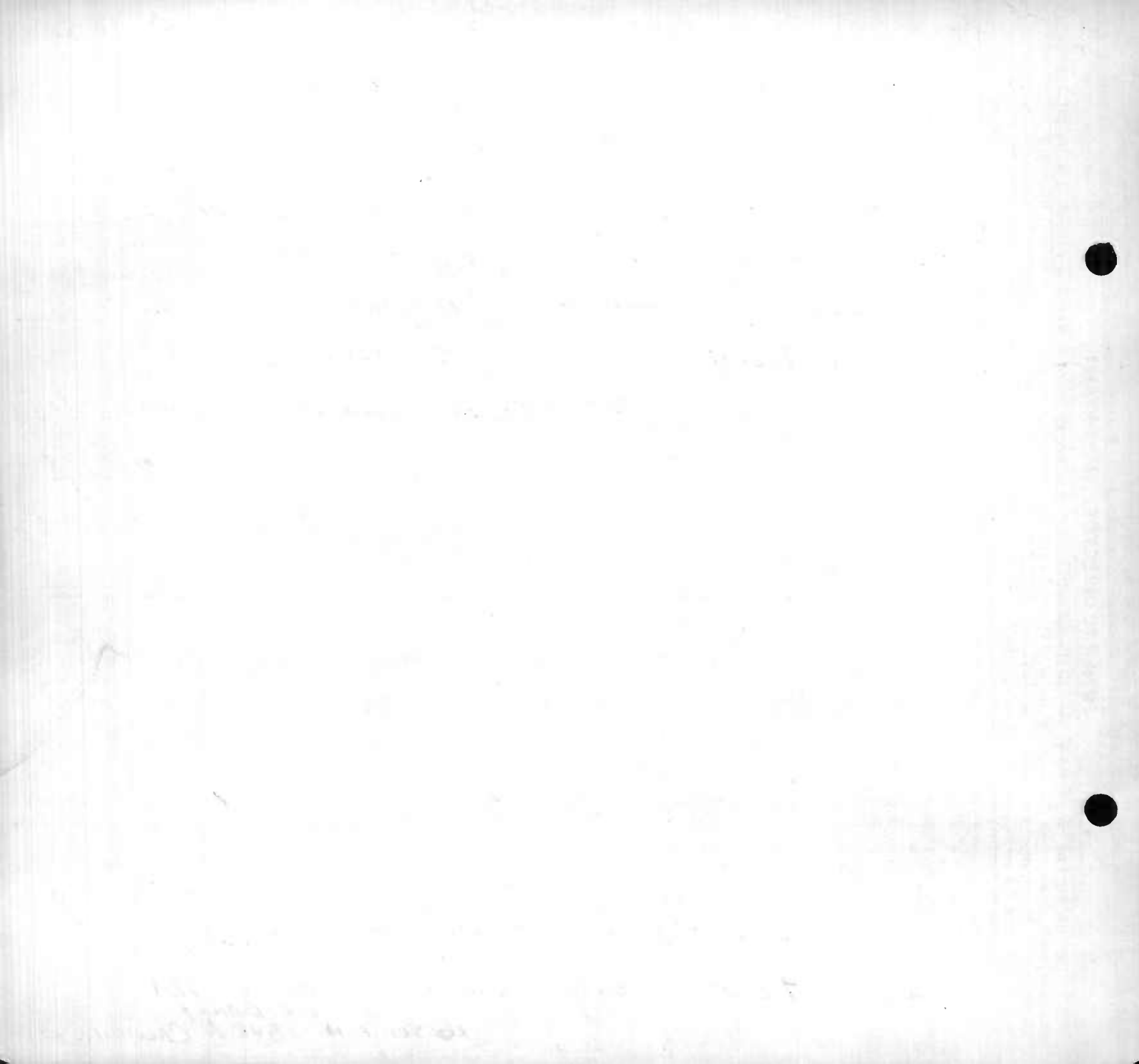
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6685 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 6685

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROSELLA QUEEN HARRIS		2. DATE AND HOUR OF DEATH 6-29-69		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1502			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001654 APPLETON STREET				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE NEGROID 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9-10-87		9. AGE (In years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME NOAH QUEEN				14. MOTHER'S MAIDEN NAME TELITHY HALL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-03-9876		17. INFORMANT ARMANELLA BANKS	
18. 404 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage (B) Cardio-Renal Disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN IDENTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-10-1966 to 6-29-1969 . that (I) (we) last saw the deceased alive on 6-28-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard H. Hunt				23B. DATE SIGNED 6/30/69		23C. PHYSICIAN'S NAME (Type) Richard H. Hunt	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM. PIC.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969				25B. NAME OF REGISTRAR James E. Gubert, M.D.		25C. FUNERAL DIRECTOR O.R. BAILEY	
26A. ADDRESS 1607 W. Mulberry St				26B. ADDRESS 1348 N. CALHOUN ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6686		BALTIMORE CITY HEALTH DEPARTMENT		69 6686	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Beatrice E. DeBlois		30 June '69 4:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 91 Jenkins Memorial Hospital 1000 Caton Avenue Baltimore, Maryland 21229			A. STATE Maryland B. COUNTY 1102		
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/14/1911		9. AGE (In years lost birthday) 57		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claims Examiner			10B. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Massachusetts
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph Emil DeBlois		
14. MOTHER'S MAIDEN NAME Hattie L. Lassard			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 003-03-1080			17. INFORMANT Jenkins Memorial Hospital 1000 Caton Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 340X 42884X Left Lower Lobe Pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple Sclerosis years		
			(B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Fx. ① clavicle + contusions 20 to fall 23 days		
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Nursing Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Jenkins Memorial - Caton Ave.	
21D. TIME OF INJURY (APPROX.) 6/7/69 - 3:45 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall from bed while being moved.	
22. I certify that (this hospital) attended the deceased from June 25 19 56 to 30 June 19 69, that (we) last saw the deceased alive on 30 June 19 69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph E. Updike M.D.				23B. DATE SIGNED 30 June 69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/69		24C. NAME of CEMETERY or CREMATORY Adams, Mass	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR Robert E. Sabers M.D.		25C. FUNERAL DIRECTOR Ralph E. Updike M.D.			

FUNERAL DIRECTOR: IMPORTANT

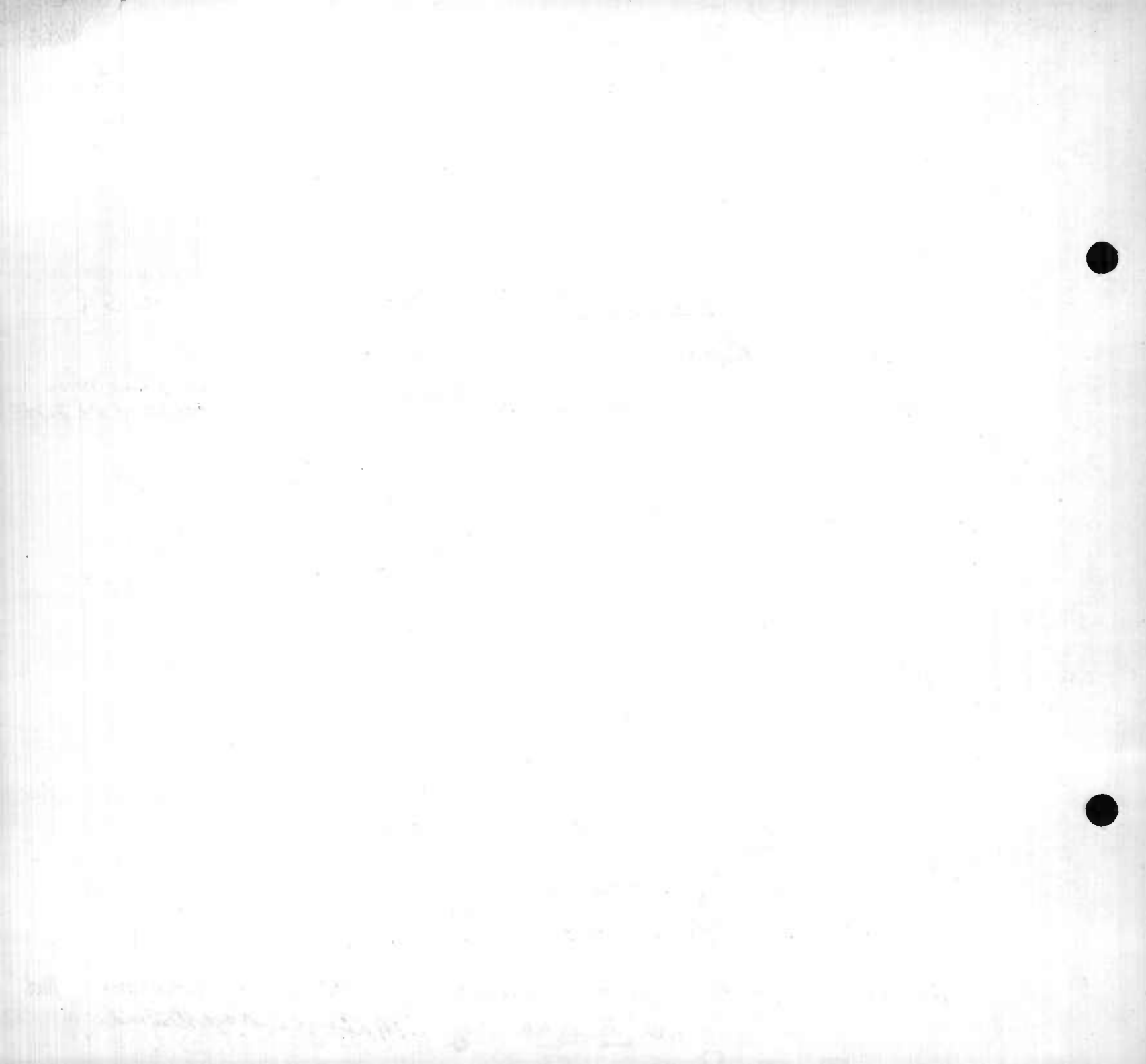
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6687
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MCWAY JOHN</u>		2. DATE AND HOUR OF DEATH <u>6-30-69</u> <u>12 40</u> <u>PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>401</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BOLTON HILL NH</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>423 W. SARA LOGA ST</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-87</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>566-14-6114</u>		17. INFORMANT <u>BOLTON HILL N.H. 1400 JOHN ST</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>arteriosclerosis generalized</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/22 1969</u> to <u>6/30 1969</u> , that (I) (we) last saw the deceased alive on <u>6/30 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>al Martin</u>				23B. DATE SIGNED <u>6/30/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>				23D. ADDRESS <u>2E Red Ct Bklyn Md 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>7/3/69</u>		24B. DATE <u>7/3/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Calvary</u>	
24D. LOCATION (City, town, or county) (State) <u>St Louis</u>		24E. FUNERAL DIRECTOR <u>James A. Schmitt</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. ADDRESS <u>James A. Schmitt</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

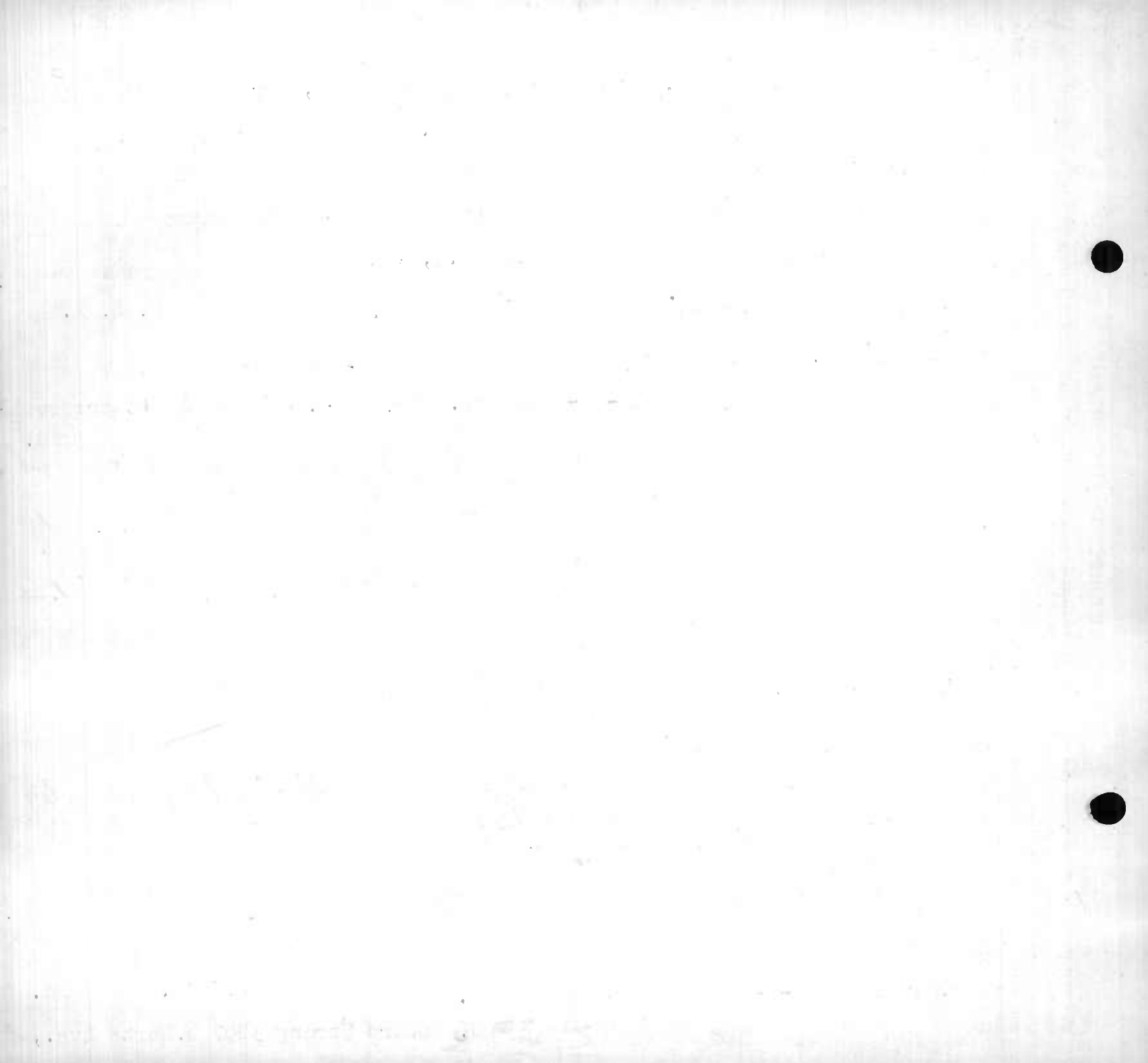
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO.	
69 6688 CERTIFICATE OF DEATH										69 6688	
1. NAME OF DECEASED (Type or Print) <i>Rhoda Emerson</i>					2. DATE AND HOUR OF DEATH <i>6/29/69</i> <i>7³⁵ a.m.</i>						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Washington</i>						
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View NEC</i>					C. CITY OR TOWN <i>Hagerstown</i>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
ADDRESS OR LOCATION <i>1650 Bonnie Ave.</i>					E. STREET AND NUMBER <i>1650 Bonnie Ave.</i>						
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/9/98</i>	9. AGE (In years lost birthday) <i>71</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>RETIRED CAFETERIA WORKER</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>SAMUEL KINSEY</i>					14. MOTHER'S MAIDEN NAME <i>SUSAN WINDERS</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>24-09-6582A</i>		17. INFORMANT <i>Mrs Ruth Middlekauff</i>			ADDRESS <i>1650 BONNIE DRIVE HAGERSTOWN Md 21240</i>		
18. <i>43791-174X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>yes</i> (B) <i>arteriosclerosis generalized</i> DUE TO, OR AS A CONSEQUENCE OF: <i>yes</i> (C) <i>CA left heart</i> <i>2/69</i>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/19</i> 19 <i>69</i> to <i>6/29</i> 19 <i>69</i> . that (I) (we) last saw the deceased alive on <i>6/29</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Al Martin</i>								Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/29/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALLAN A. MACOTT M.D.</i>								23D. ADDRESS <i>2 E Reed ST BALTIMORE Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>7/2/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ROSE HILL CEMETERY</i>				24D. LOCATION (City, town, or county) (State) <i>HAGERSTOWN WASHINGTON Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1969</i>				25B. NAME OF REGISTRAR <i>John E. Taylor</i>				25C. FUNERAL DIRECTOR <i>John E. Taylor</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6689	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Glenn M. Rowzee		June 29, 1969 7:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 4901 Wetheredsville Road			Md. 2833		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male			White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Maintenance Supervisor			Md. Paper Cup Corp.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles A. Rowzee			Nannie H. Heskett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			218-10-3151		Mrs. Clarence J. Moran 4901 Wetheredsville Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			18. Emphysema (acute) - 6 years		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
None					No.
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from April 13 - 1964 to 6/29 1969, that (I) last saw the deceased alive on 6/27/69 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE					23B. DATE SIGNED
Earl L. Chambers					7/1/69
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS
DR. EARL L. CHAMBERS					100 W. Cold Spring Lane BALTIMORE MD.
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-2-1969		Meadowridge Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1969		Robert E. Haden, M.D.		G. Howard Strong 3207 W. North Ave.,	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

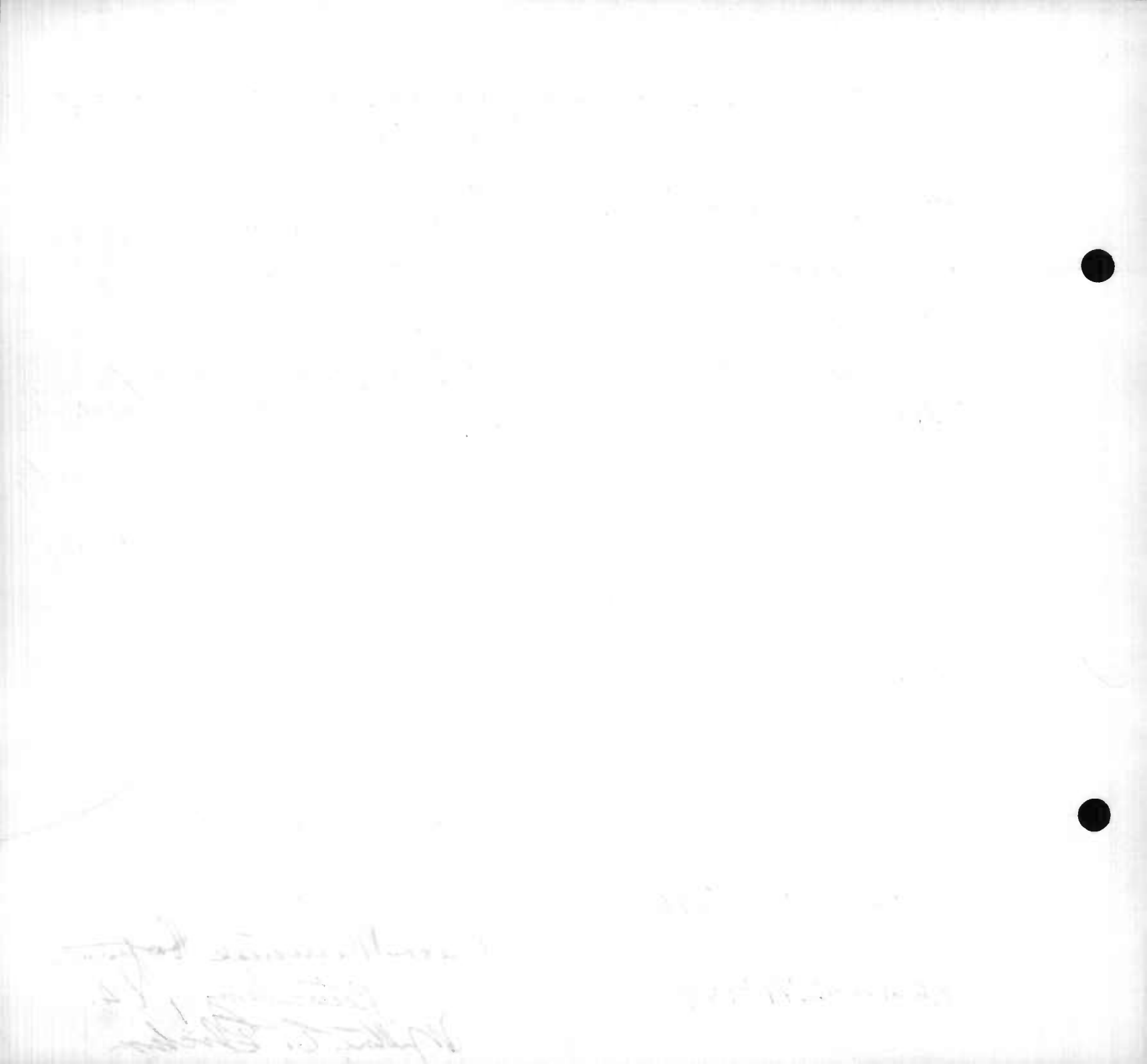
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VIOLA WILLIAMS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1969 12:30 a.m.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1303	
7. RACE Colored		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jan 24, 1926		E. STREET AND NUMBER 2332 Druid Hill Ave.	
10. AGE (In years lost birthday) 42		11. BIRTHPLACE (State or foreign country) Trenton, N.J.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Anderson	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		15. MOTHER'S MAIDEN NAME Jesse Statton	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. John Anderson 1502 Patton Pl	
19. 162.1		CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lungs (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NO	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? NO	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 1, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 3, 69	
24C. NAME OF CEMETERY or CREMATORY Westport, Md		24D. LOCATION (City, town, or county) (State) Westport, Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Frank T. Elshorn		ADDRESS 1129 N. Carroll St	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 6691		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6691	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) CARTER, LAURA ANN (Griffin)				2. DATE AND HOUR OF DEATH July 1st 1969 6:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2712			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 426 HOWELL Terr.		71218	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05/22/1928	9. AGE (In years last birthday) 41	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Mr. Julius Newman				14. MOTHER'S MAIDEN NAME Maggie Ann Crowley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Nathiel Carter Address same husband	
18. 15411 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cachexia		04/28/69	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) adenocarcinoma rectum DUE TO, OR AS A CONSEQUENCE OF:		07/1/69	
				(C) _____		D.H.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 5/1/69, 6/2/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 6/28/69		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 04/28 19 69 to 7/1 19 69 that (I) (we) last saw the deceased alive on 7/1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Pius Y. Cho				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Pius Y. Cho				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		24B. DATE 7/2/69		24C. NAME of CEMETERY or CREMATORY Petersburg, Va.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR Robert E. J. Jones, M.D.		25C. FUNERAL DIRECTOR Wm. E. E. E. E.		ADDRESS	



W. J. [illegible]
[illegible]
[illegible]

100-100-100-100-100-100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) KEVIN GREGORY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> June 27, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1969 6:50 P M	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 907	
7. RACE Negro		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 11-20-59		E. STREET AND NUMBER 2626 Cecil Ave.	
10. AGE (In years last birthday) 9		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWIN GREGORY	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME HELEN BRICE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT HELEN GREGORY 2626 CECIL AVE.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple blunt injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 6-27-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal injury	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hillen Road, 426 feet North of Havenwood Road	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 6-27-69 5:40 P m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Pedestrian struck by car		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-28-69	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-1-69	
24C. NAME OF CEMETERY or CREMATORY ARBUTUS-MEM. PARK		24D. LOCATION (City, town, or county) (State) ARBUTUS Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1969		25B. NAME OF REGISTRAR E. E. Taber, M.D.	
25C. FUNERAL DIRECTOR DONALD GLOYER FOR JOSEPH KNIGHT-1639 N. BROADWAY		ADDRESS	

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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BUREAU OF PLANT INDUSTRY

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED

(Type or Print)

EMMA HARRIS (TAYLOR)

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

June 26, 1969

2:45 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

HOPKINS HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 26, 1969

2:45 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

806

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

11-13-35

10. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1621 E. North Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS HARRIS

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NONE

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

DOROTHY TAYLOR

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

DOROTHY WILLIAMS 1408 E. BIDDLE ST.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Acute Hemorrhagic Pancreatitis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Fatty Metamorphosis of Liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7-2-69

24C. NAME of CEMETERY or CREMATORY

MT AUBURN

24D. LOCATION (City, town, or county) (State)

BALTIMORE Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

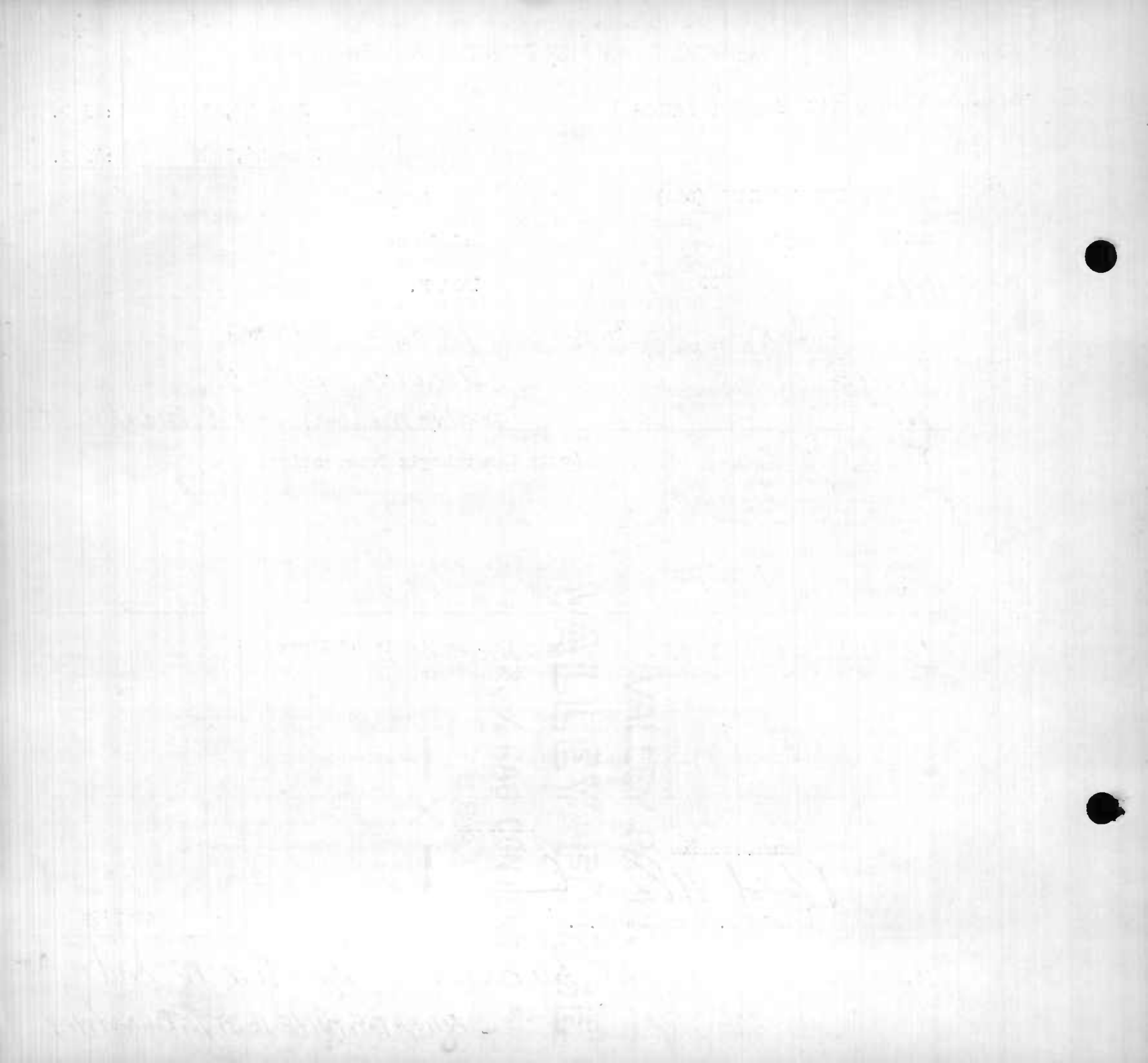
25C. FUNERAL DIRECTOR

ADDRESS

JUL 2 1969

Robert E. Fisher, M.D.

KNIGHT, F. HOME 1639 N. BROADWAY



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6694

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN H. LEE

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

June 25, 1969

10:15 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1907 Homewood Avenue (DOA)

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

June 25, 1969

10:15 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

908

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9-8-1907

10. AGE (In years last birthday)

61

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1907 Homewood Avenue

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JIM LEE

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

14B. KIND OF BUSINESS OR INDUSTRY

ANCHOR-CONST. CORP.

15. MOTHER'S MAIDEN NAME

ELMY

LEE

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

215-09-7509

18. INFORMANT

MARIAN BROWDER 4004 OAKFORD AVE

ADDRESS

19. 4124 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/25/69

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

7-1-69

24C. NAME of CEMETERY or CREMATORY

M.T. ALBURN CEMETERY

24D. LOCATION (City, town, or county) (State)

BALTIMORE MD

25A. DATE REC'D BY HEALTH DEPT.

JUL 2 1969

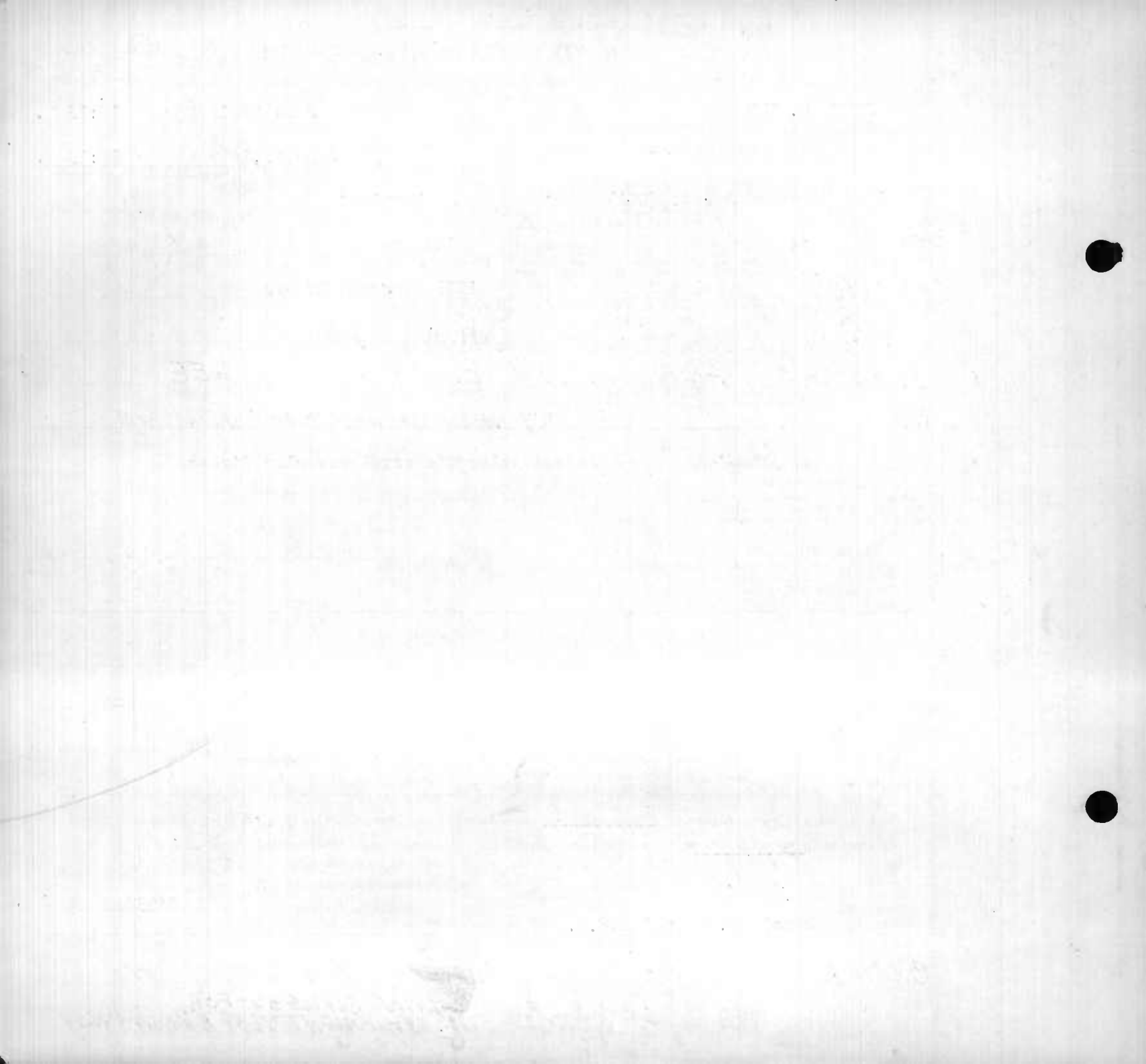
25B. NAME OF REGISTRAR

Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR

CALVIN SCRUGGS - FOR JOSEPH KNIGHT 1639 N. BROADWAY

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6695 CERTIFICATE OF DEATH				REG. NO. 69 6695	
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			DE SHAZO, JAMES F.		
2. DATE AND HOUR OF DEATH			6-27-69 1 1.50 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 THE JOHNS HOPKINS HOSPITAL			MARYLAND BALTIMORE CITY 833		
5. SEX			C. CITY OR TOWN		
MALE			BALTIMORE		
6. RACE			D. INSIDE CITY LIMITS?		
NEGRO			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			E. STREET AND NUMBER		
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			2631 E. PRESTON STREET 21213		
8. DATE OF BIRTH			9. AGE (In years last birthday)		
10-1-1892			76		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Farmer			Woodsdale, N.C.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Self			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGE DESHAZO			IDA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			244-12-5905 J1		
17. INFORMANT			ADDRESS		
Mrs Ada Smith			2631 E. Preston St.		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			Pulmonary Embolus 1 day		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Myocardial Infarction, Diabetes mellitus 1 wk, may 1969		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 6/16 19 69 to 6/27 19 69					
that (2) (we) last saw the deceased alive on 6/27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Joel Engleston M.D.			6/27/69		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
JOEL ENGLESTON			Johns Hopkins Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Removal			6-3-69		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Allen Chapel Cemetery			Woodsdale, N.C.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
JUL 2 1969			Robert E. Taylor, M.D.		
25C. FUNERAL DIRECTOR			ADDRESS		
Rudolph J. Collick			2431 E. Oliver St.		

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
69 6696 CERTIFICATE OF DEATH											
REG. NO. 69 6696											
BIRTH NO.				1. NAME OF DECEASED <u>DELONES</u> (Type or Print) <u>ADA A MAST</u>				2. DATE AND HOUR OF DEATH <u>JUNE 29 1969</u> <u>11:35 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 CHURCH HOME & HOSPITAL</u>						4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>BELAIR</u> B. COUNTY <u>HARFORD CO.</u> C. CITY OR TOWN <u>BELAIR</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>520 MAST ST.</u>					
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-91</u>		9. AGE (In years last birthday) <u>78</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Apartment House</u>				11. BIRTHPLACE (State or foreign country) <u>VIRGINIA TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Madron</u>						14. MOTHER'S MAIDEN NAME <u>Oliver S. Reese</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-46-0061</u>		17. INFORMANT <u>DANA NELSON</u>				ADDRESS <u>119 STONELEIGH BELAIR, MD.</u>	
18. CAUSE OF DEATH											
<p>18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>ACUTE MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>											
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <u>June 8</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>				20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 8</u> 19 <u>69</u> to <u>June 29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>June 29</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Corazon Z. Vergara, M.D.</u>								23B. DATE SIGNED <u>June 29, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>	
23D. ADDRESS <u>Church Home Hospital 100 N. Broadway Balt. Md. 31</u>								23E. ATTENDING PHYS. <input type="checkbox"/>		23F. MED. DIRECTOR <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 2, 1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>				24D. LOCATION (City, town, or county) (State) <u>BEL AIR, HARFORD CO., MARYLAND 21014</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Jaber, M.D.</u>				25C. FUNERAL DIRECTOR <u>Joseph William Foster</u>			
								ADDRESS <u>101 Broadway Williams St. BEL AIR, Maryland 21014</u>			

18

18-19

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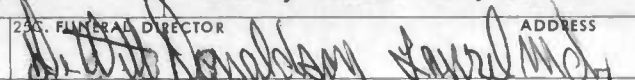
18-19

18-19

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6697 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH REG. NO. 69 6697

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY MURPHY HOWARD		2. DATE AND HOUR OF DEATH 6/22/1969 1:30 pm M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Howard Co.		
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL			C. CITY OR TOWN HANOVER		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER Rt 1 Box 136 RIDGE RD		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/02	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Towel Factory		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? US			13. FATHER'S NAME John R. Murphy		
14. MOTHER'S MAIDEN NAME Maria Emily Gates			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-12-2674			17. INFORMANT Gene Heflin		
ADDRESS 2924 Union Rd. Vineland, N.J.					
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE METASTASES DUE TO, OR AS A CONSEQUENCE OF: PRIMARY COLON CANCER METASTASES TO LIVER & LUNG</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
19A. DATE OF OPERATION 6/22/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal operation		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/22/69 to 6/22/69 19 69 , that (I) (we) lost saw the deceased alive on 6/22/69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 6/22/69		
23C. PHYSICIAN'S NAME (Type) L.S. Manik in			23D. ADDRESS Fulton, Howard Co., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/25/69		24C. NAME OF CEMETERY or CREMATORY St. Pauls Cemetery	
24D. LOCATION (City, town, or county) (State) Fulton, Howard Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR James E. Gabe, Md.		25C. FUNERAL DIRECTOR 	
ADDRESS					

Called Hospital no operation performed during
this admission. T.

Dr. J. W. McDaniel to St. L.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K420

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6698
BIRTH NO. 69 6698		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) VICTORIA KOWALSKI		2. DATE AND HOUR OF DEATH 6-23-69 7:12 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 104 C. CITY OR TOWN CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1006 S. BELMONT AVE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/1880	9. AGE (In years last birthday) 89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219-18-5359		17. INFORMANT ADDRESS ROSE KRAJEWSKI 510 CRISFIELD AVE.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) MASSIVE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. APTERIOSCEPOTIC HEART DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from 6-23-69 19 to 6-23 19 69 that (H) (we) last saw the deceased alive on 6-23 19 69 and that (H) (we) (our) applan death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Cezar A. Lopez MD		23B. DATE SIGNED 6-23-69		23C. PHYSICIAN'S NAME (Type) CEZAR A. LOPEZ MD
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6/27/69		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		
25B. NAME OF REGISTRAR J. E. Tabor, M.D.		25C. FUNERAL DIRECTOR ADDRESS BYRON D. KACZOROWSKI 2323 FLEET ST.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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6699

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69

6699

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM L. CONNELLY

2. DATE AND HOUR OF DEATH

June 29, 1969

6:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

Wilkins & Caton Avenues

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

523 S. Longwood Street 21223

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3-7-1903

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Service Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Royal-McBee Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William E. Connelly

14. MOTHER'S MAIDEN NAME

Charlotte Reichenbecker

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-01-7782

17. INFORMANT

Mr. Charles D. Connelly 5425 W. North Ave.

ADDRESS

21207

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Occlusion

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Thrombosis 10/11

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Sudden

Oct 1967

10/11/67

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/23 1957 to 6/29 1969.

that (I) (we) last saw the deceased alive on 6/24 1969 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. E. W. Johnson

DEGREE

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

6/24/69

23C. PHYSICIAN'S
NAME (Type)

Dr. E. W. Johnson

DEGREE

23D. ADDRESS

3432 Frederick Avenue, Balto., Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-3-69

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEP

JUL 3 1969

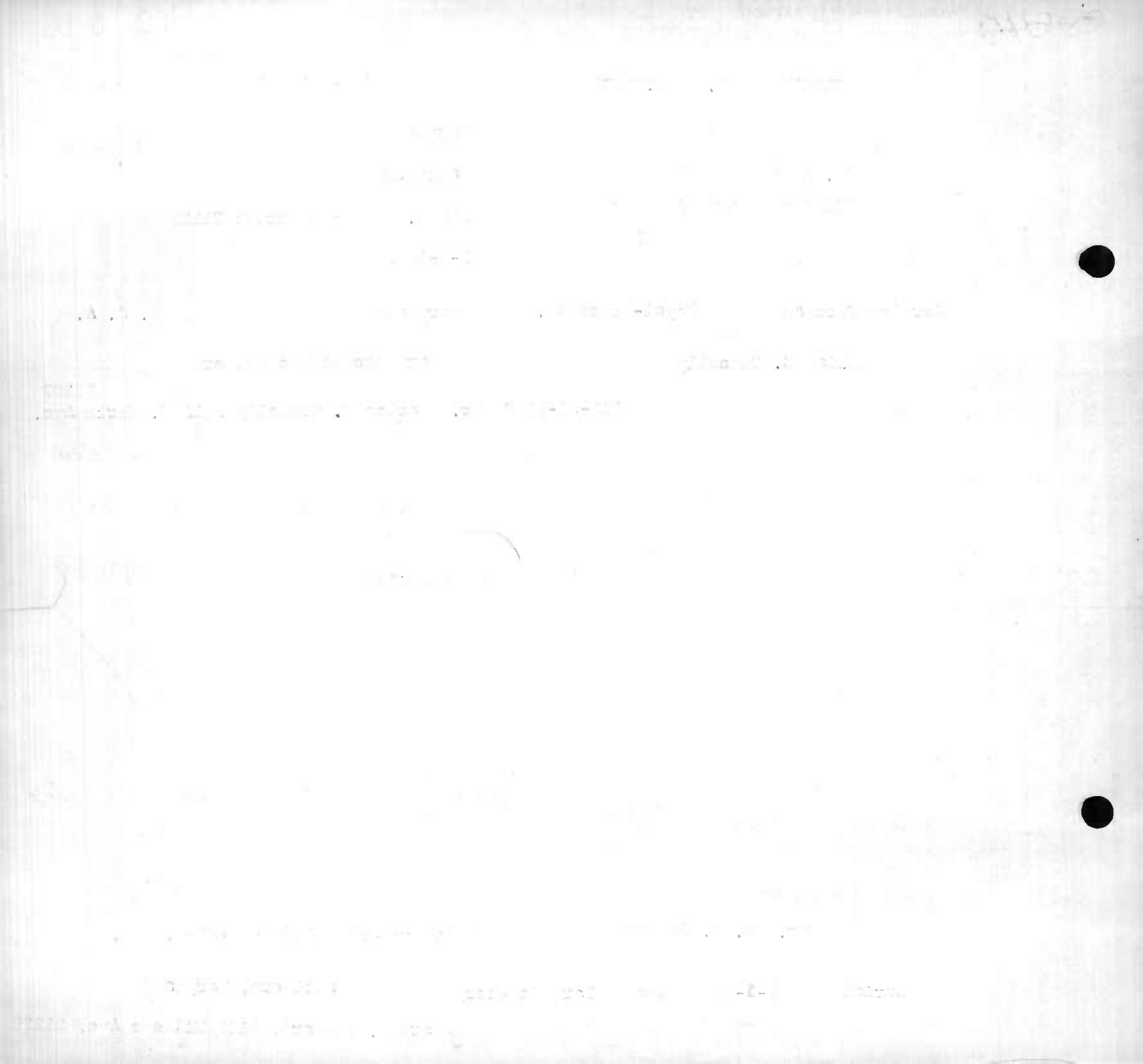
25B. NAME OF REGISTRAR

James E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6700				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 6700	
1. NAME OF DECEASED (Type or Print) PARKS NELLIE				2. DATE AND HOUR OF DEATH 6/29/69 11:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2102 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1342 James St. 21223			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Aug 28 1901	9. AGE (In years lost birthday) 67	10. CITIZEN OF WHAT COUNTRY? America U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Godfrey Lange Kutig				14. MOTHER'S MAIDEN NAME Sarah Fischer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. 21865929		17. INFORMANT Clarence L. Parks 1342 James St. 21223	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CVA atrial fibrillation CVA				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/25/69 to 6/29/69 and that (I) (we) last saw the deceased alive on 6/29/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Surinder				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/29/69	
23C. PHYSICIAN'S NAME (Type) SURINDER				23D. ADDRESS F.S.H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1969		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6701		BALTIMORE CITY HEALTH DEPARTMENT		69 6701	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) POPP FREDERICK KARL		2. DATE AND HOUR OF DEATH JUNE 29 1969 7:30A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2005 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2122 WILHELM STREET 21223			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/25/97	9. AGE (in years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN POPP		14. MOTHER'S MAIDEN NAME ANNA MILLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705 07 6493		17. INFORMANT ADDRESS ST AGNES HOSP CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 342 IX-2509 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Respiratory arrest. Parkinson disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF: (C) A.S.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 06/28/69 19 to 06/29/69 19 that (X) (we) last saw the deceased alive on 06/29/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Shams, M.D.		23B. DATE SIGNED 06 29 69		23C. PHYSICIAN'S NAME (Type) A. SHAMS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69		24C. NAME of CEMETERY or CREMATORY St. Pauls Lutheran Cemetery	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS ST AGNES HOSP CATON & WILKENS AVE			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard	
25D. ADDRESS 4107 Wilkens Ave. 21229					

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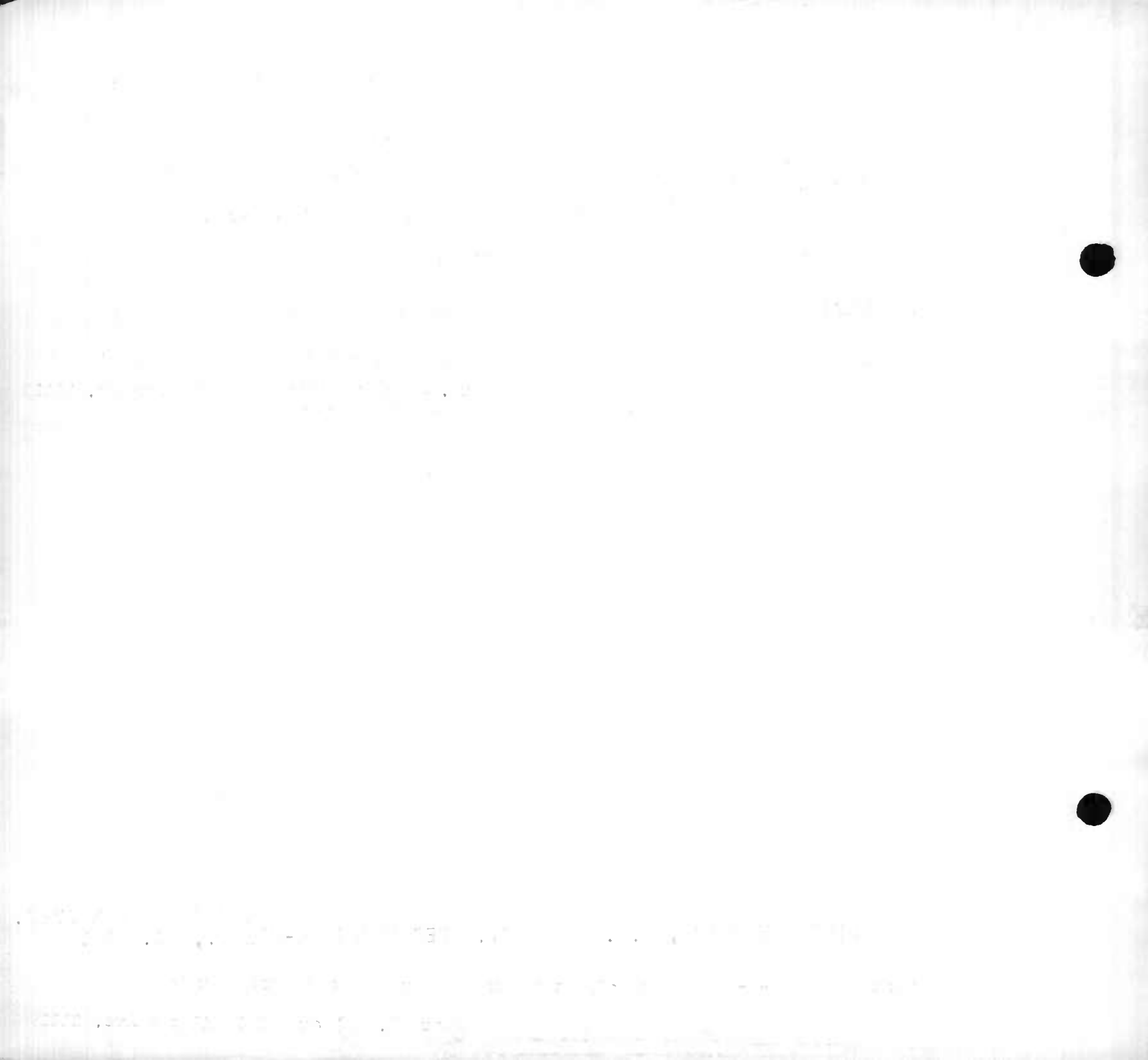
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6702	
BIRTH NO.		69 6702		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		BERTHA HUBL		2. DATE AND HOUR OF DEATH JUNE 29, 1969 3:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
40 ST AGNES HOSPITAL WILKENS & CATON AVES BALTIMORE MARYLAND 21229		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 01 18 87		9. AGE (In years last birthday) 82		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HUNGARY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MARTIN BILD DEC'D		14. MOTHER'S MAIDEN NAME EVA (FRANK) BILD DEC'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217090396		17. INFORMANT Mrs. Amelia Spittel 1513 McHenry St. 21223 ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Perforated Duodenal ulcer, 2. (B) Aortic aneurysm. DUE TO, OR AS A CONSEQUENCE OF: (C) A.S.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from JUNE 22 19 69 to JUNE 29 19 69 that (I) (we) last saw the deceased alive on JUNE 29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE A. Shams, M.D.		23B. DATE SIGNED 6/29/69	
23C. PHYSICIAN'S NAME (Type) PIRZADEH SHAMS, M.D.		23D. ADDRESS WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Howard H. Hubbard	
25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 69 6703	
BIRTH NO. 69 6703					
1. NAME OF DECEASED (Type or Print) GIMELLI, MICHAEL JOHN			2. DATE AND HOUR OF DEATH JUNE 29, 1969 8:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Howard Co. 21227 6300		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			C. CITY OR TOWN ELKRIDGE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 06/08/83		9. AGE (in years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CEMENT WORKER		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME MICHAEL GIMELLI		
14. MOTHER'S MAIDEN NAME PHILIPINA MATZA			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 079-10-5822			17. INFORMANT ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE GI Bleeding due to DUE TO, OR AS A CONSEQUENCE OF: (B) esophageal varices & secondary DUE TO, OR AS A CONSEQUENCE OF: (C) to liver cirrhosis secondary to obstruction due stones		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 25, 19 69 to JUNE 29 19 69 that (X) (we) last saw the deceased alive on JUNE 29 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Muhammad AF2AR M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7-3-69		24C. NAME of CEMETERY or CREMATORY St. Peter's Cemetery
24D. LOCATION (City, town, or county) (State) Oswego, New York			25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		
25B. NAME OF REGISTRAR Robert E. [Signature] M.D.			25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229		

24.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

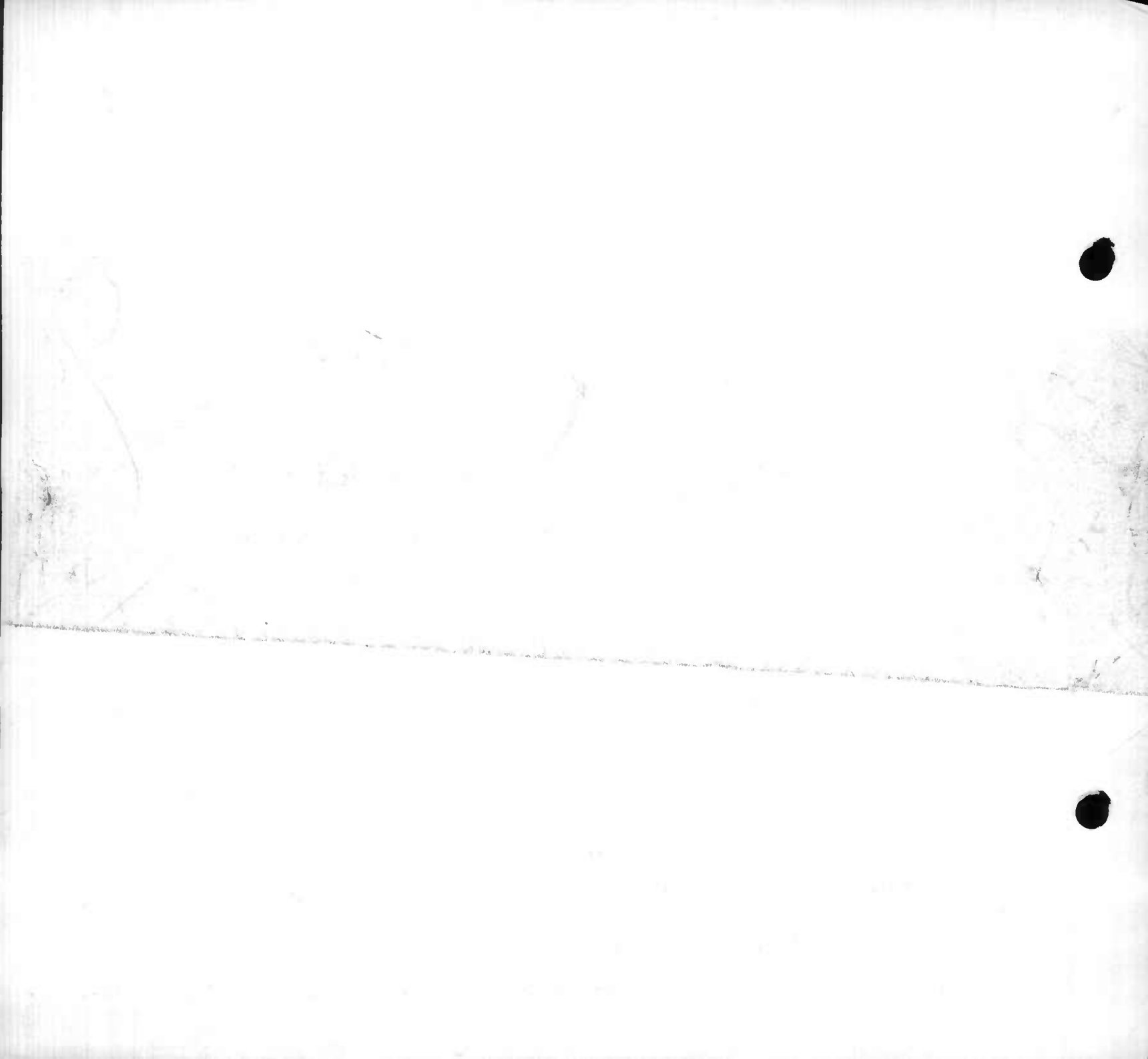
BALTIMORE CITY HEALTH DEPARTMENT				X	REG. NO. 69 6704	
BIRTH NO. 69-11872		69 6704		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY JOHNSON				2. DATE AND HOUR OF DEATH 6-29-69 12:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND , WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY A.A.		
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN ANNAPOLIS		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE		6. RACE NEGRO		8. DATE OF BIRTH 6-28-69		9. AGE (In years lost birthday) XXXX
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME ANDREA JOHNSON		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. 776.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) apneic spells ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. prematurity				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 10/28 19 69 to 10/29 19 69 and that (I) (we) last saw the deceased alive on 10/29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE R. N. Shelf, MD				23B. DATE SIGNED 6/29/69		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS				
R. N. SHELF		THE JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6/29/69		24C. NAME of CEMETERY or CREMATORY The Johns Hopkins Hosp.		24D. LOCATION (City, town, or county) (State) 601 N. Broadway, Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR 66 HOSPITAL DISPOSAL		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6705		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 6705	
BIRTH NO. <u>Harford Co. Md.</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RICKY PETTIBONE				2. DATE AND HOUR OF DEATH <u>6/29/69</u> - <u>10</u> <u>15</u> A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY HARFORD	
				C. CITY OR TOWN EDGEWOOD		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2303 ROTH ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-69	9. AGE (In years last birthday) ---	If Under 1 Yr. Months: Days: 19 00	If Under 24 Hrs. Hours: Min: 19 00	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LAWRENCE PETTIBONE				14. MOTHER'S MAIDEN NAME SHEILA WARNETT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 331 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest				10 minutes			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diaphragmatic Hernia			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6/28/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diaphragmatic Hernia		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>69</u> to <u>6/29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <i>Gary S. Rachelefsky</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/29/69</u>	
23C. PHYSICIAN'S NAME (Type) GARY S. RACHELEFSKY				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Crementation		6/29/69		The Johns Hopkins Hosp.		601 N. Broadway, Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1969		Robert E. Fisher, M.D.		HOSPITAL DISPOSAL			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>Columbia, S.C.</u> <u>69 6706</u>					REG. NO. <u>69 6706</u>				
1. NAME OF DECEASED (Type or Print) <u>Carlton Douglass Corley</u>					2. DATE AND HOUR OF DEATH <u>6/30/69</u> <u>10:35 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>					A. STATE <u>South Carolina</u> B. COUNTY <u>V-37</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Irmo</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
					E. STREET AND NUMBER <u>Rt 1 Box 28-4</u>				
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/28/68</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Columbia S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN HEDRY ESTEAD</u>					14. MOTHER'S MAIDEN NAME <u>FRANCES Corley</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>FRANCES Corley</u> ADDRESS <u>Rt 1 Box 28-4</u>			
18. <u>320.01</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac + Respiratory Arrest</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u>H. Flu, type B, Meningitis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>10 minutes</u>				
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6/30/69</u> 19 <u>07</u> to <u>6/30</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>David Walker, MD</u> DEGREE					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>6/30/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>David Walker, MD</u> DEGREE					23D. ADDRESS <u>Johns Hopkins Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-2-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Old Grove Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Irmo South Carolina</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u>			25C. FUNERAL DIRECTOR <u>Calvin B. Scruggs</u> ADDRESS <u>1422 E. Preston St.</u>				

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DM (11/11/11) 11/11/11

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

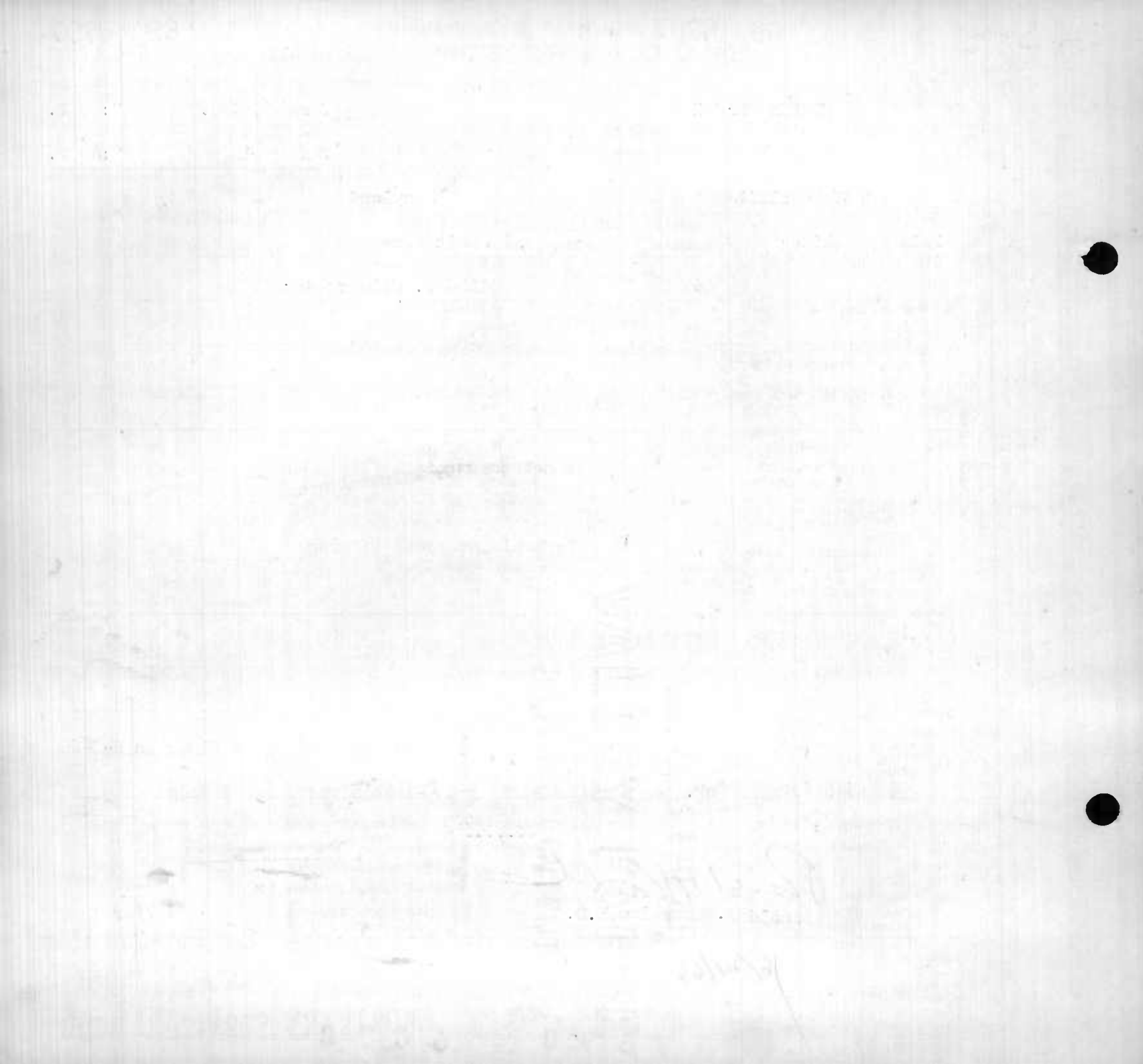
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE HASKINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 6, 1969 Hour 2:40 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 6, 1969 Hour 2:40 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1101	
9. DATE OF BIRTH		10. AGE (In years last birthday) 46 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. E 980.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable overdose of drugs (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No) yes
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Found unconscious on floor on 6-3-69		22F. HOW DID INJURY OCCUR? Probable overdose of drugs
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 6-3-69 Unk. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/7/69		

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 6/24/69	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or square)
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969	25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	25C. FUNERAL DIRECTOR ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6708
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN HARRISON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 30, 1969 Hour 1:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour May 30, 1969 1:10 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 21 N. Carey Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1802	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	

MEDICAL CERTIFICATION	19. CAUSE OF DEATH E 929 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subdural hematoma complicated by Cirrhosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE Subdural hematoma complicated by Cirrhosis (B) of the liver DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
	20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No) yes
	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. Unk.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk.	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unk.
22D. TIME OF INJURY (APPROX.) May 1969	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Unk.

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 5/30/69
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 6/24/69	24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	24D. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHO
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS	

Handwritten signature

10/20/90

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT												
69 6709 CERTIFICATE OF DEATH												
REG. NO. 69 6709												
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EARL ETUE				2. DATE AND HOUR OF DEATH 6/26/69 9:00 A.M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY AA						
FULL NAME OF HOSPITAL OR INSTITUTION MEREX Hospital						C. CITY OR TOWN JESSUP			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER Box 534						5. SEX M			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 6/11/16		9. AGE (in years last birthday) 53		
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA						12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME WILLIAM ETUE						14. MOTHER'S MAIDEN NAME BERTHA JONES						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. 485X I CAUSE OF DEATH												
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF: suspected.						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) Bronchopneumonia; Septicemia Thrombocytopenia DUE TO, OR AS A CONSEQUENCE OF: days.						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).												
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) PENDING E Anatomy Board.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR?				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6-23 19 69 to 6-26 19 69 that (I) (we) last saw the deceased alive on 6-26 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE Philip H. Moore						23B. DATE SIGNED 6-26-69		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS ANATOMY BOARD OF MARYLAND						
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 6/30/69		24C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHD				
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969				25B. NAME OF REGISTRAR Robert E. Farber, M.D.				25C. FUNERAL DIRECTOR ADDRESS				

FUNERAL DIRECTOR: IMPORTANT

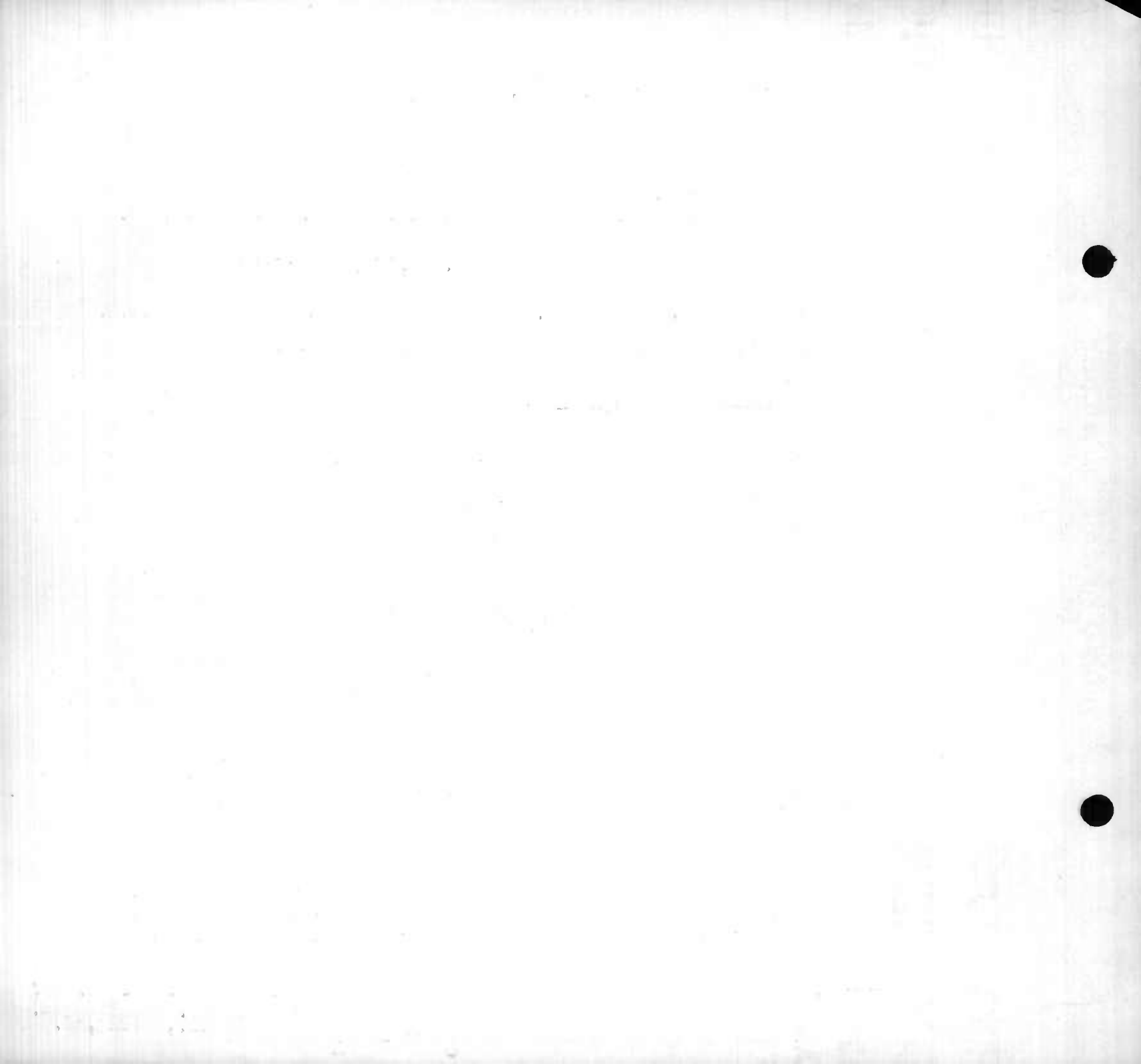
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>69-09851 69 6710</u>					REG. NO. <u>69 6710</u>				
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Willis</u>					2. DATE AND HOUR OF DEATH <u>6/4/69</u> <u>2:27 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland</u>					A. STATE <u>MD</u>		B. COUNTY <u>1402</u>		
					C. CITY OR TOWN <u>Balt</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1739 Druid Hill Ave</u>									
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/4/69</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clarence Broom</u>					14. MOTHER'S MAIDEN NAME <u>Carolyn Lee Willis</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother</u>			ADDRESS <u>1739 Druid Hill Ave.</u>	
18. <u>247.61</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Sequestration</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>2:22 AM - 6/4/69</u> 19 <u>69</u> to <u>2:27 AM - 6/4/69</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/4</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Rosevelt Taylor, Jr. M.D.</u>					23B. DATE SIGNED <u>6/4/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Rosevelt Taylor, Jr. M.D.</u>		
23D. ADDRESS <u>BALTIMORE BOARD OF MARYLAND</u>					23E. LOCATION (City, town, or county) (State) <u>JOHNS HOPKINS MEDICAL SCHOOL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6/25/69</u>		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR		25D. ADDRESS <u>6 MORTUARY SERVICE - BCHD</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-655-69 6711		69 6711		REG. NO. 69 6711	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Bearman (WILLIAM V. BEARMAN)		June, 30, 1969 8:03 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224		A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 735 S. Ponca St. Baltimore, Md. 21224			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1897	9. AGE (In years lost birthday) 72	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Md. Drydock Co.		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick Bearman		14. MOTHER'S MAIDEN NAME Mary Carlisle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-6373A		17. INFORMANT ADDRESS BCH RECORDS: 4940 Eastern Ave. Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 44491 CAUSE OF DEATH Cardiop. arrest? (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: etiology ? pulm. embolus? MI (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 h.					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Heat stroke					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/29 19 65 to 6/30 19 65, that (I) (we) lost saw the deceased alive on 6/30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lee J. Cordova MD.		23B. DATE SIGNED 6/30/65		23C. PHYSICIAN'S NAME (Type) Lee J. Cordova MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) 7-3-69. Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.		24E. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224		24F. FUNERAL DIRECTOR 901 S. Conowing St. Balto., 21224, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles J. Zeiler	



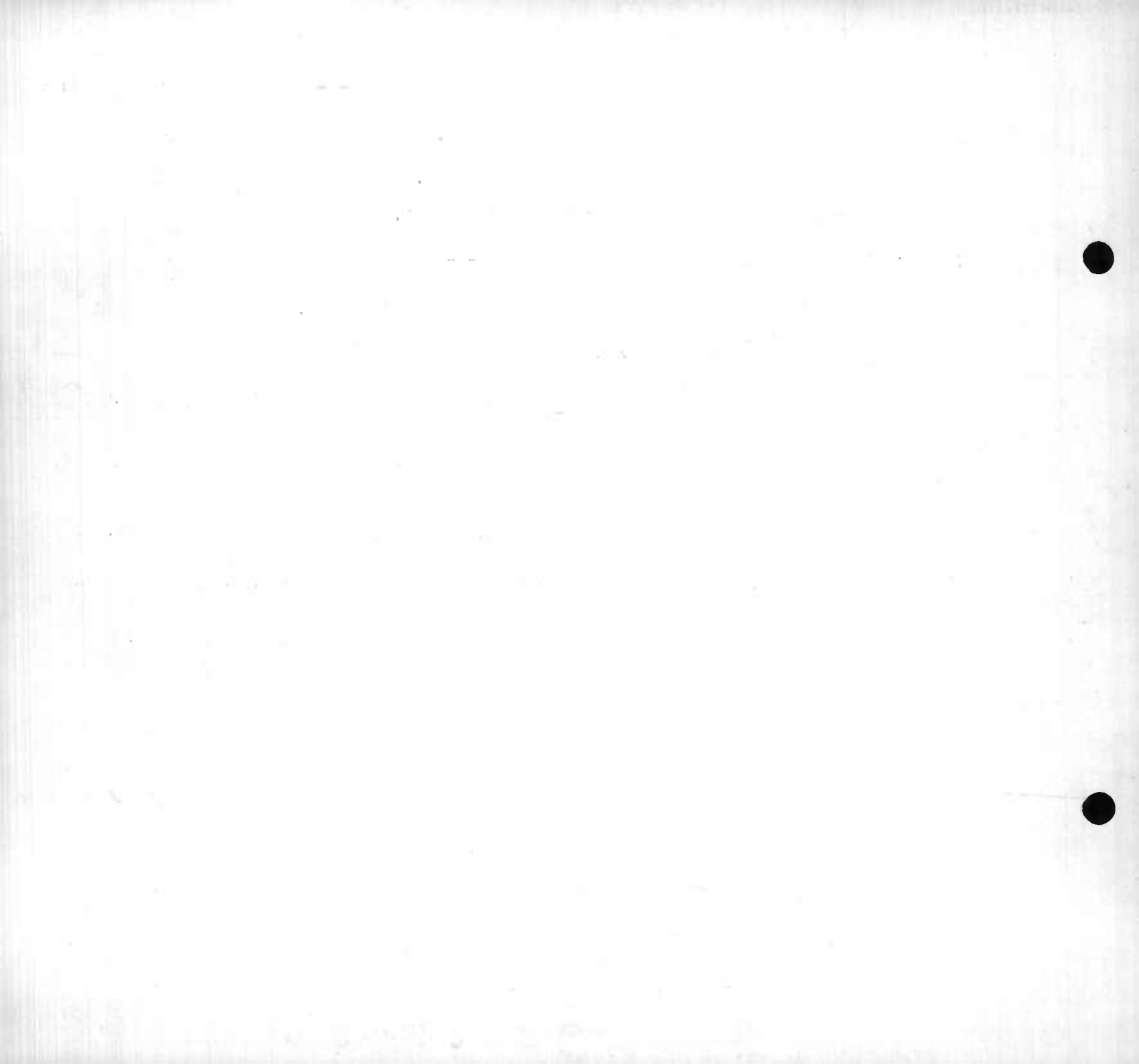
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6712 CERTIFICATE OF DEATH

REG. NO. 69 6712

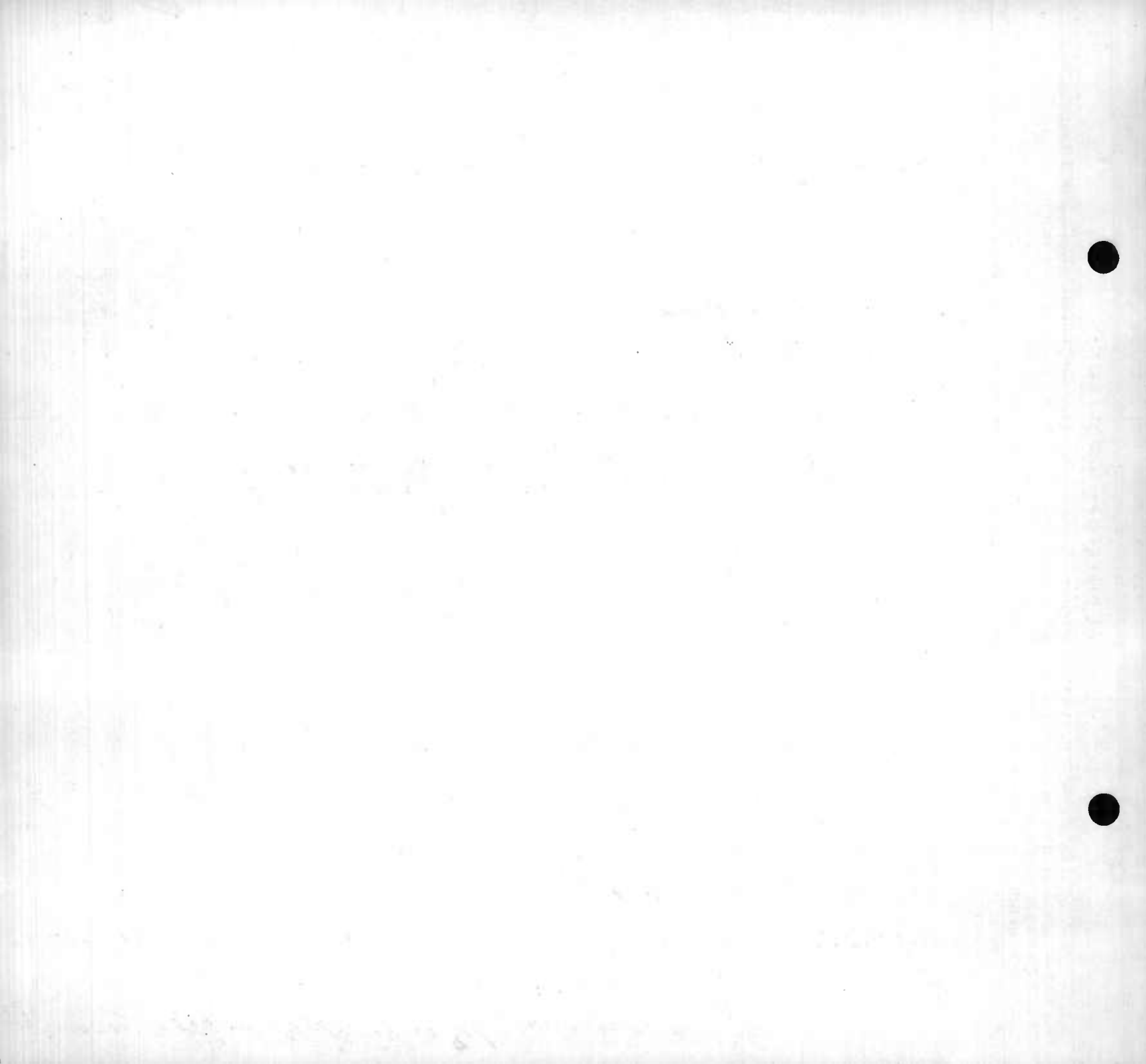
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bertha Johnson		2. DATE AND HOUR OF DEATH 7-1-69 1:10 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1101			
FULL NAME OF HOSPITAL OR INSTITUTION 90 B olton Hill Nursing & Convalescent Center		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 817 St. Paul Street		5. SEX Female		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-7-1885		9. AGE (In years lost birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter Cheswick		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-1114		17. INFORMANT MRS Bertha Johnson ADDRESS 817 St Paul St	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE cerebral thrombosis central DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: years			
(C) arteriosclerosis gen. DUE TO, OR AS A CONSEQUENCE OF: years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5/15 19 66 to 7/1 19 69 , that (I) (we) lost saw the deceased alive on 7/1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE ALLAN H. MARY		23B. DATE SIGNED 7/2/69		23C. PHYSICIAN'S NAME (Type) ALLAN H. MARY MD	
23D. ADDRESS 2 E Paul St Balt Md 21202		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/69	
24C. NAME OF CEMETERY or CREMATORY LORRAINE IN GM		24D. LOCATION (City, town, or county) Balto Md		(State) Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Galt, M.D.		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc ADDRESS Balto Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6713				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6713			
1. NAME OF DECEASED (Type or Print) JOSEPH McFADDEN				2. DATE AND HOUR OF DEATH 7/2/69 at 4 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND - 1 B. COUNTY 1901							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE GOOD SAMARITAN HOSPITAL 15601 SOUTH RAVEN BLVD BALTIMORE MARYLAND 21212				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 1600 FRANKLIN STREET 21223							
5. SEX M	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-13-06 63	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FREIGHT ELEVATOR OP. WHEATON MD		11. BIRTHPLACE (State or foreign country) SALEM VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES McFADDEN				14. MOTHER'S MAIDEN NAME SALLIE COMPTON							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217011034				17. INFORMANT ADDRESS HOSPITAL RECORDS AND WIFE			
18. 1487 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BAROCCASMA HYPOTHARYNX AND TONGUE WITH EXTENSIVE METASTASIS				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (FEB. 1968) 16 months			
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/16 1969 to 7/2 1969 , that (I) (we) last saw the deceased alive on 7/2/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Caridad E. Gonzalez M.D.				23B. DATE SIGNED 7/2/69							
23C. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ M.D.				23D. ADDRESS THE GOOD SAMARITAN HOSPITAL BALTO MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burned				24B. DATE 7-5-69				24C. NAME OF CEMETERY or CREMATORY MT AUBURN			
24D. LOCATION (City, town, or county) (State) BALTIMORE											
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969				25B. NAME OF REGISTRAR Robert E. Taylor M.D.				25C. FUNERAL DIRECTOR ADDRESS 1000 68th St			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>276-200</u> <u>69 6714</u>
69 6714						Aloysius
BIRTH NO.						29 June 1969 4:00 AM
1. NAME OF DECEASED (Type or Print) <u>Wright, Urban Allen</u>			2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>5</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>XUSPHS Balto, Maryland</u>			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3303 Woodland</u>		<u>Balto, Md.</u>	
5. SEX <u>♂</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Sept 1987</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper hanger</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Home Building</u>		11. BIRTHPLACE (State or foreign country) <u>MD. Hagerstown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Wilfred A. Wright</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WWII-Mexico</u>			
16. SOCIAL SECURITY NO. <u>216 01 2589</u>			17. INFORMANT <u>Chart & Mrs. Mary Louise Wright</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4/2, 31 & 202, 1</u>			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>BRONCHOPNEUMONIA 17 DAYS</u> <u>ARTERIOSCLEROTIC HEART DISEASE YEARS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC HEART DISEASE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>			<u>MYCOSIS FUNGOIDES YEARS</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>29 June 1969</u> to <u>29 June 1969</u> , that (I) (we) last saw the deceased alive on <u>29 June 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>John P. Sutherland, MD</u>				23B. DATE SIGNED <u>29 June 69</u>		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2 JUL 1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>		
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1969</u>				
25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. E. Lowell</u>				
ADDRESS <u>Lemmon 4611 Park Heights Ave.</u>						

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645

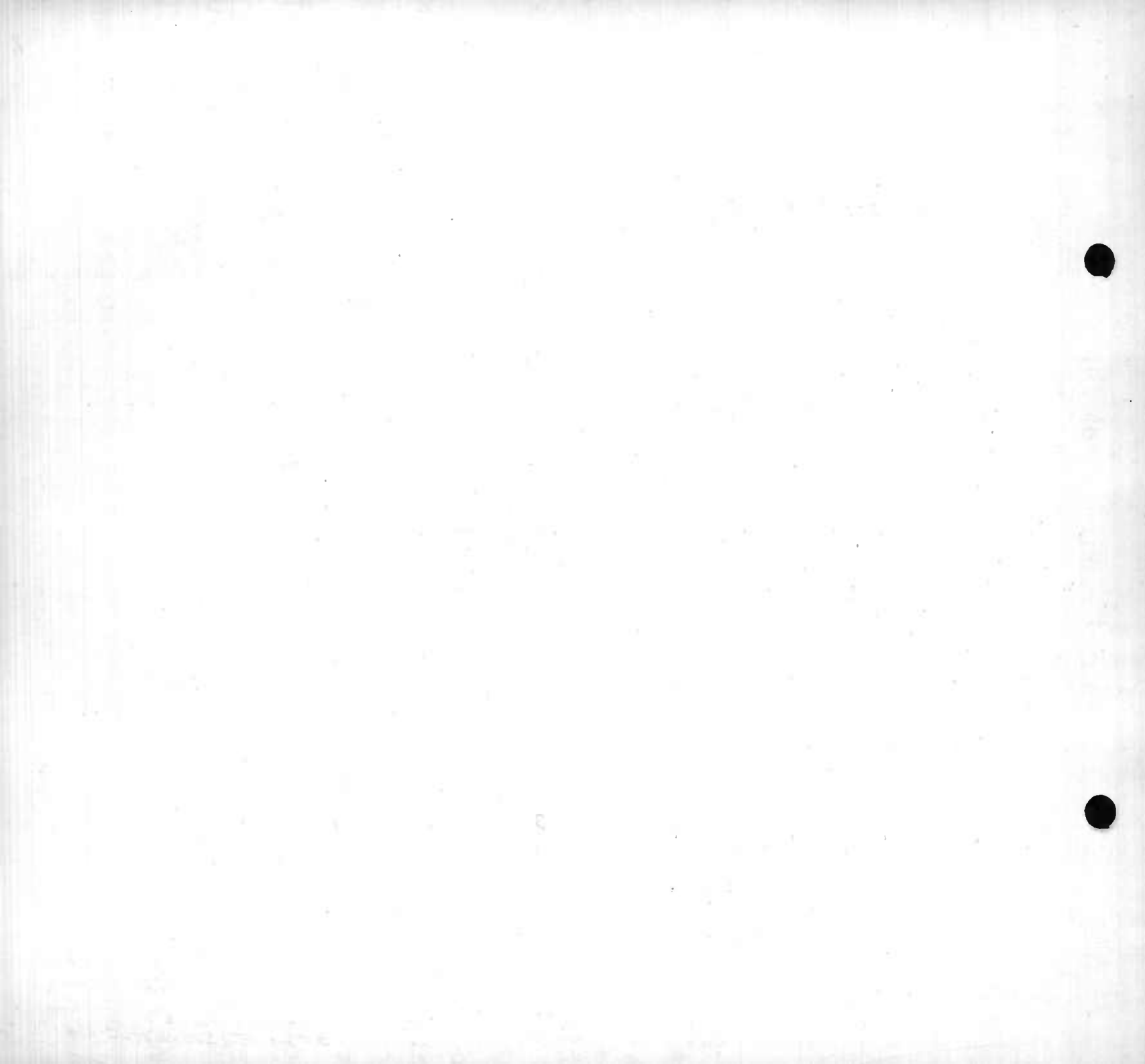
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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69 6715 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X REG. NO. 69 6715

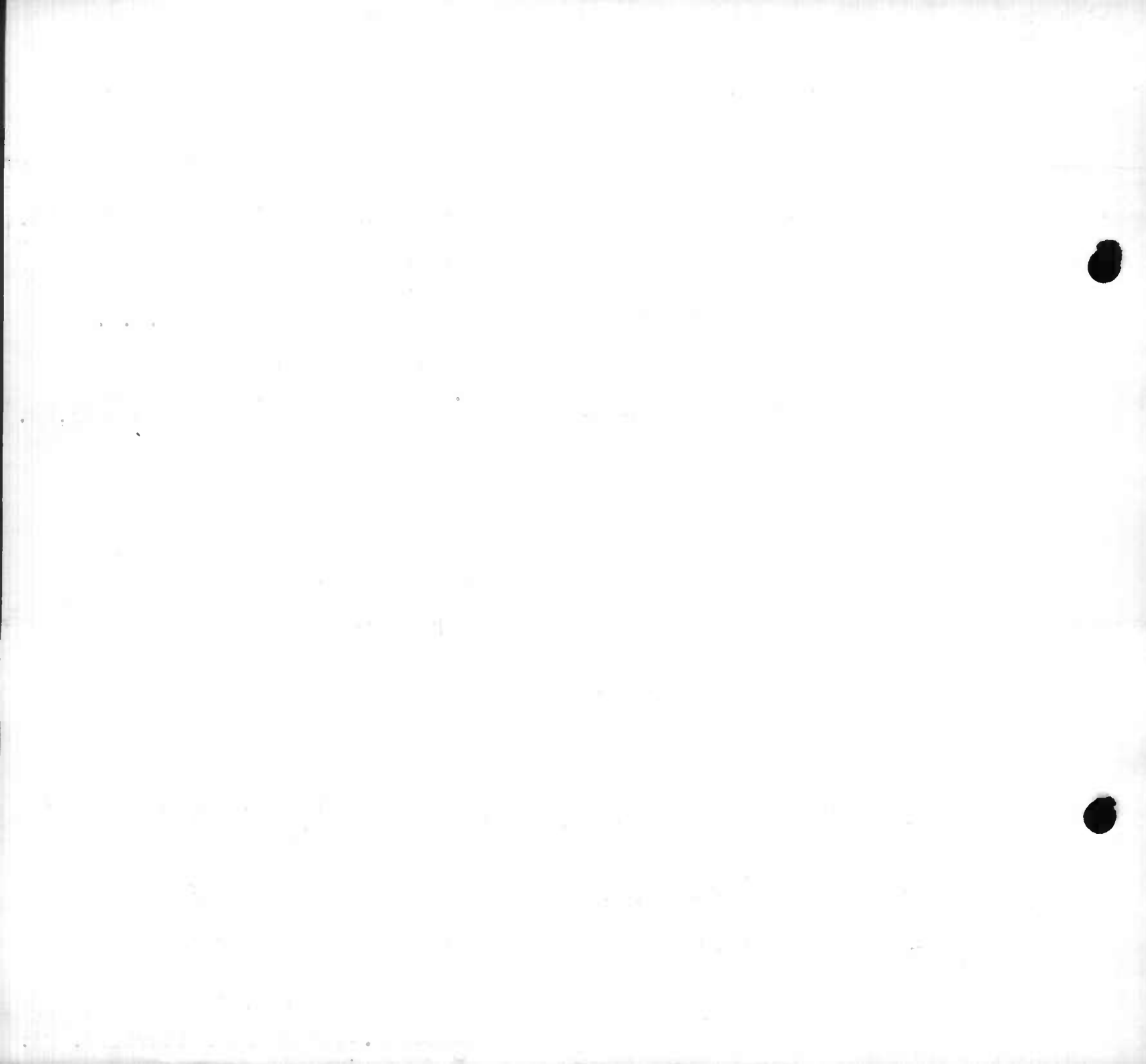
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ARNOLD LOHER		June 30, 1969 7:40 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
US Public Health Service Hospital 3100 Wyman Parkway				Florida	
				C. CITY OR TOWN Marathon	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1250 Ocean View Ave.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/13	9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Switzerland	
13. FATHER'S NAME Victor Loher				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes CG 1942-1945				16. SOCIAL SECURITY NO. ?	
17. INFORMANT Records- US PHS Hospital, Balto, Md.				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Malignant lymphoma				Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from May 26 19 69 to June 30 19 69, that (X) (we) last saw the deceased alive on June 30 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James M Weaver				23B. DATE SIGNED 6/30/69	
23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL, (Specify) BURIAL		24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY UNKNOWN	
24D. LOCATION Miami, Florida		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR James E. Taylor, M.D.		25C. FUNERAL DIRECTOR MATTHEWS FUNERAL HOME	
				ADDRESS 3021 EASTERN AVE. BALTO, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 69 6716	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 69 6716 </div>					
1. NAME OF DECEASED (Type or Print) BOWLING, James Manford			2. DATE AND HOUR OF DEATH 7/1/69 9:05 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Maryland </div> <div> B. COUNTY Harford </div> </div>		
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 2, 26		9. AGE (In years last birthday) 42		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Bowling		
14. MOTHER'S MAIDEN NAME Lora Ann Pruitt			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 226-28-1000		
16. SOCIAL SECURITY NO. 226-28-1000			17. INFORMANT Mrs. Gladys Irene Bowling		
18. ADDRESS Box 23, Sharon Road Forest Hill, Md.			19. MEDICAL CERTIFICATION		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aspiration			18. CAUSE OF DEATH 21050		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Multiple Enter Fistula			18. CAUSE OF DEATH 21050		
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). pseudomonas pneumonia			18. CAUSE OF DEATH 21050		
19A. DATE OF OPERATION 5/28/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA STOMACH		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from June 1 1969 to July 1 1969 that (1) (we) last saw the deceased alive on July 1 1969 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Baker MD				23B. DATE SIGNED 7-1-69	
23C. PHYSICIAN'S NAME (Type) John W. Baker MD				23D. ADDRESS Johns Hopkins Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/1969		24C. NAME of CEMETERY or CREMATORY Welcome Home Baptist	
24D. LOCATION (City, town, or county) (State) Bel Air, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969			
25B. NAME OF REGISTRAR Charles E. Kurtz		25C. FUNERAL DIRECTOR Jarrettsville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

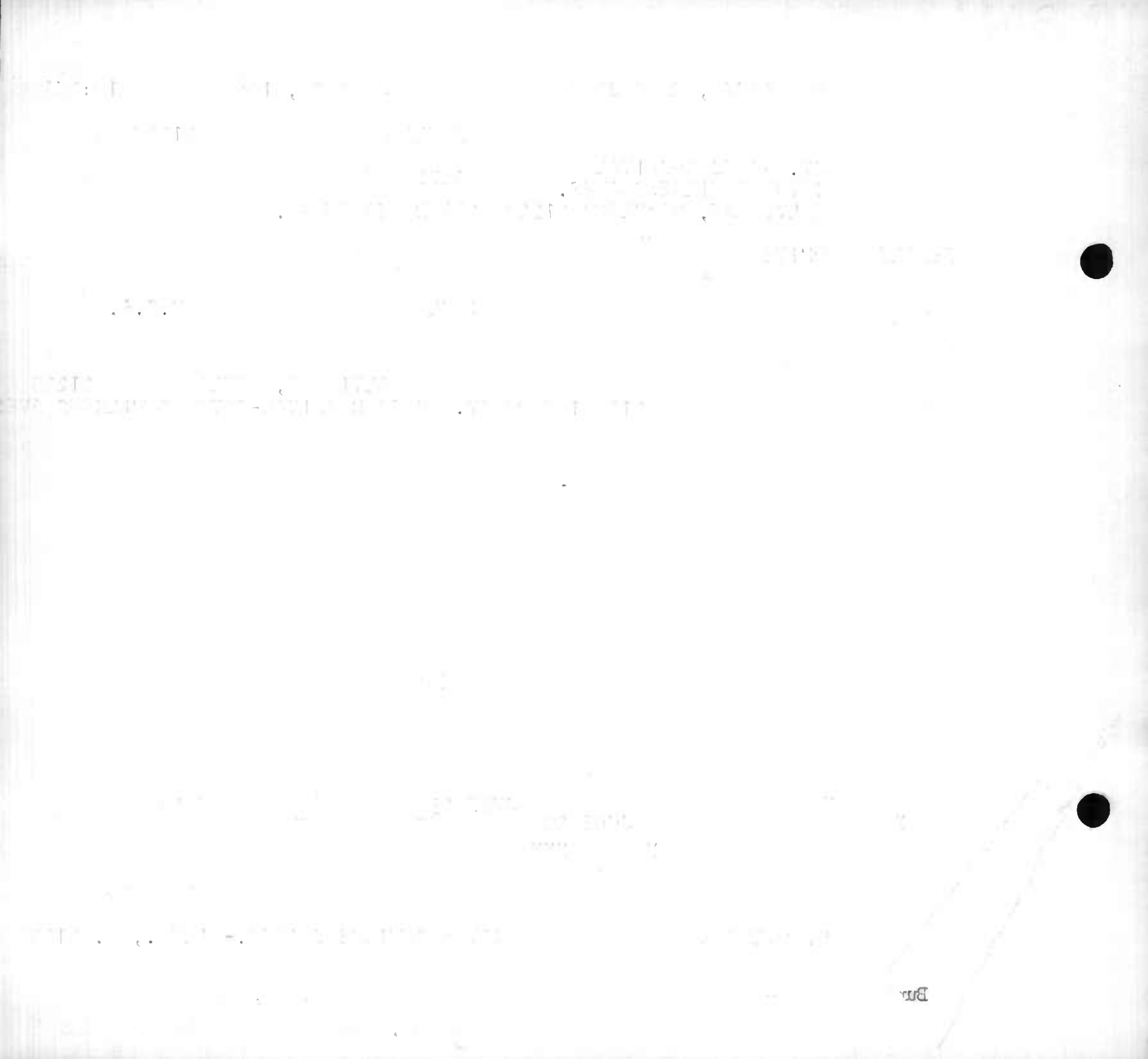
BALTIMORE CITY HEALTH DEPARTMENT			
69 6717		REG. NO. 69 6717	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ZELLER HOWARD Lafayette	
2. DATE AND HOUR OF DEATH 6/28/68 6:50 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2544		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Franklin Square Hospital	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 813 Washburn Ave 25		5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/3/20		9. AGE (in years last birthday) 48	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker		11. KIND OF BUSINESS OR INDUSTRY All State Boiler Co.	
12. BIRTH PLACE (State or foreign country) Baltimore, Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME DAVID AUGUSTUS ZELLER		15. MOTHER'S MAIDEN NAME LILLIAN PASTUREFIELD	
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1942		17. SOCIAL SECURITY NO. 219079328	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CA Lung & Metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, BRONCHOPNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/28/68 19 68 to 6/28/68 19 68 and that (I) (we) lost saw the deceased alive on 6/28/68 19 68 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Surinder		23B. DATE SIGNED 6/28/68	
23C. PHYSICIAN'S NAME (Type) SURINDER		23D. ADDRESS FSA	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2, 1969	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 14001 Ritchie Hwy 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

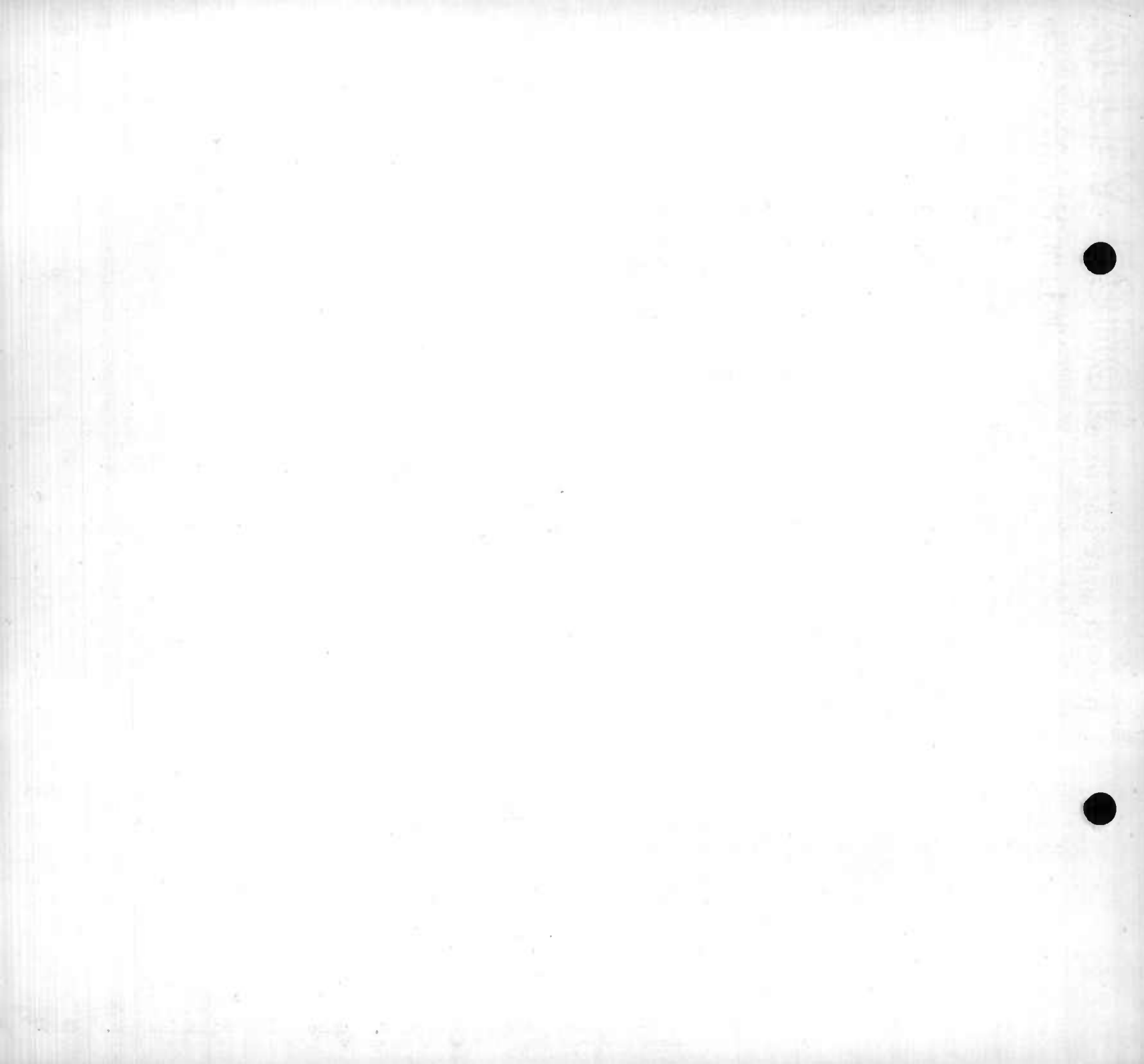
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO.		69 6718		69 6718	
1. NAME OF DECEASED (Type or Print)		BUMBARGER, EMMA JANE		2. DATE AND HOUR OF DEATH JUNE 29, 1969 10:25A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229		MARYLAND ARCO. 21225 5200	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 17, 1894		9. AGE (In years last birthday) 75		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 01 5505		17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., head failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterio sclerotic cerebral Vascular disease + cerebro-vascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 23 19 69 to JUNE 29 19 69 that (X) (we) last saw the deceased alive on JUNE 29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.		23A. SIGNATURE P. Shams M.D.		23B. DATE SIGNED 06/29/69	
23C. PHYSICIAN'S NAME (Type) P. SHAMS MD		23D. ADDRESS CATON & WILKENS AVES.-BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR George J. Gorge	
25C. FUNERAL DIRECTOR 4001 Ritchie Hwy 21225					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6719
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA GERTRUDE ROGERS		2. DATE AND HOUR OF DEATH 6-29-69 9:45 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY AA CO.		
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 401 FAIRFAX AVE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-82	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHART	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) POSSIBLE PULMONARY EMBOLUS - MINUTES ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CORONARY ARTERY DISEASE - YEARS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). GENERAL THROMBOSIS					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/17/69 to 6/29/69 , that (I) (we) last saw the deceased alive on 6/29/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. G. Tolentino				23B. DATE SIGNED 6/29/69	
23C. PHYSICIAN'S NAME (Type) MARIANO A. TOLENTINO		23D. ADDRESS NORTH CHARLES GEN. HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR George J. Conce	
25D. ADDRESS 4001 Ritchie Hwy.		25E. CITY, STATE, ZIP 21225			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6720

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RUTH I OTTEN

2. DATE
OF DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

June 29, 1969

9:38 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

SINAI HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 29, 1969

9:38 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Female

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9. DATE OF BIRTH

Oct. 19, 1927

10. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3631 Keystone Avenue

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Textile Worker.

14B. KIND OF BUSINESS OR INDUSTRY

Mills.

15. MOTHER'S MAIDEN NAME

?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

217-20-7711

18. INFORMANT

ADDRESS

Wm/L. Otten 3631 Keystone Ave.

19. 5-77.81

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Fatty Liver

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Chronic Pancreatitis

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial.

24B. DATE

July 2, 1969

24C. NAME of CEMETERY or CREMATORY

Meadowridge Mem. Park.

24D. LOCATION

(City, town, or county)

(State)

Dorsey Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

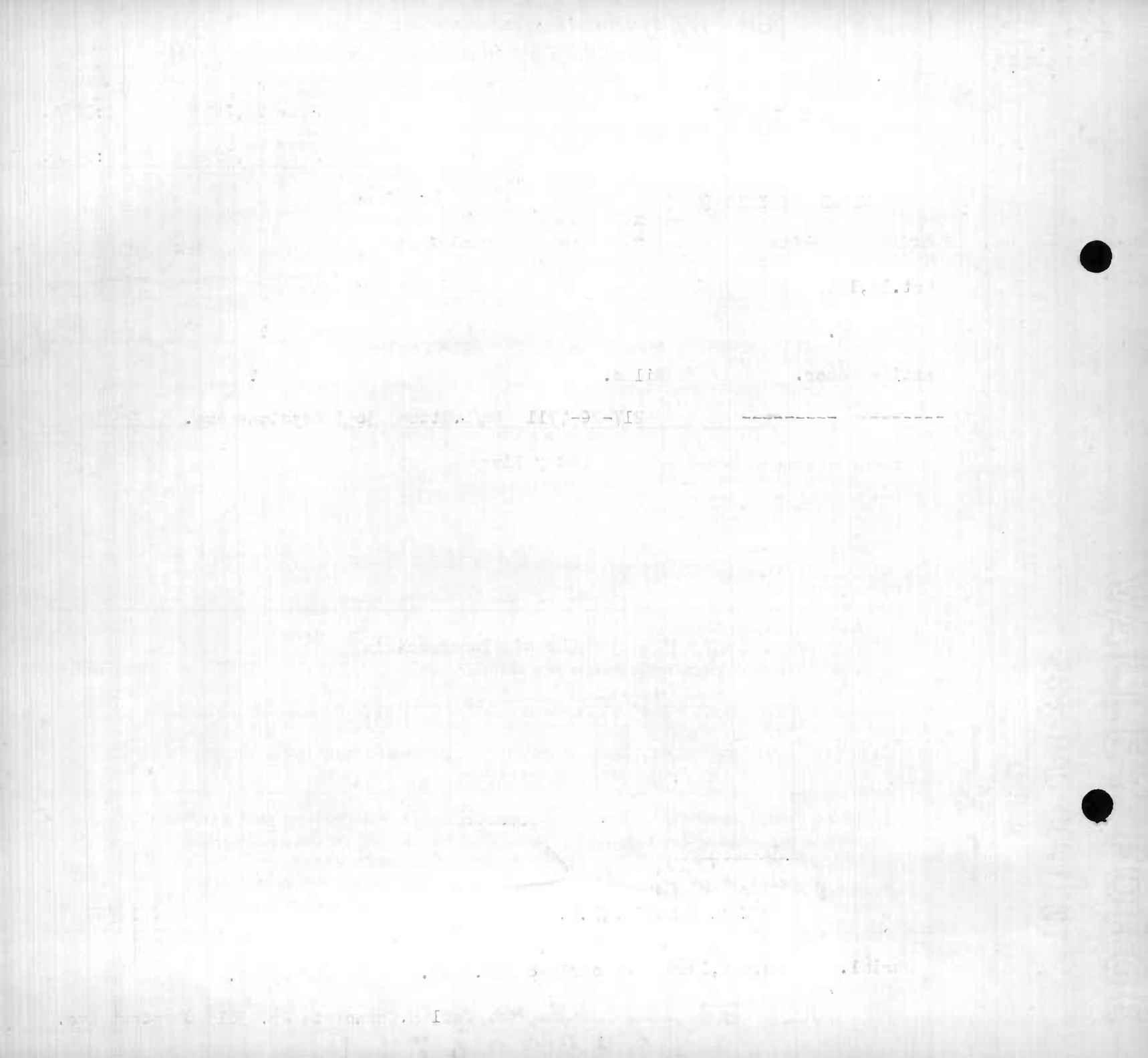
25C. FUNERAL DIRECTOR

ADDRESS

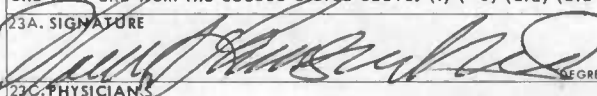
JUL 3 1969

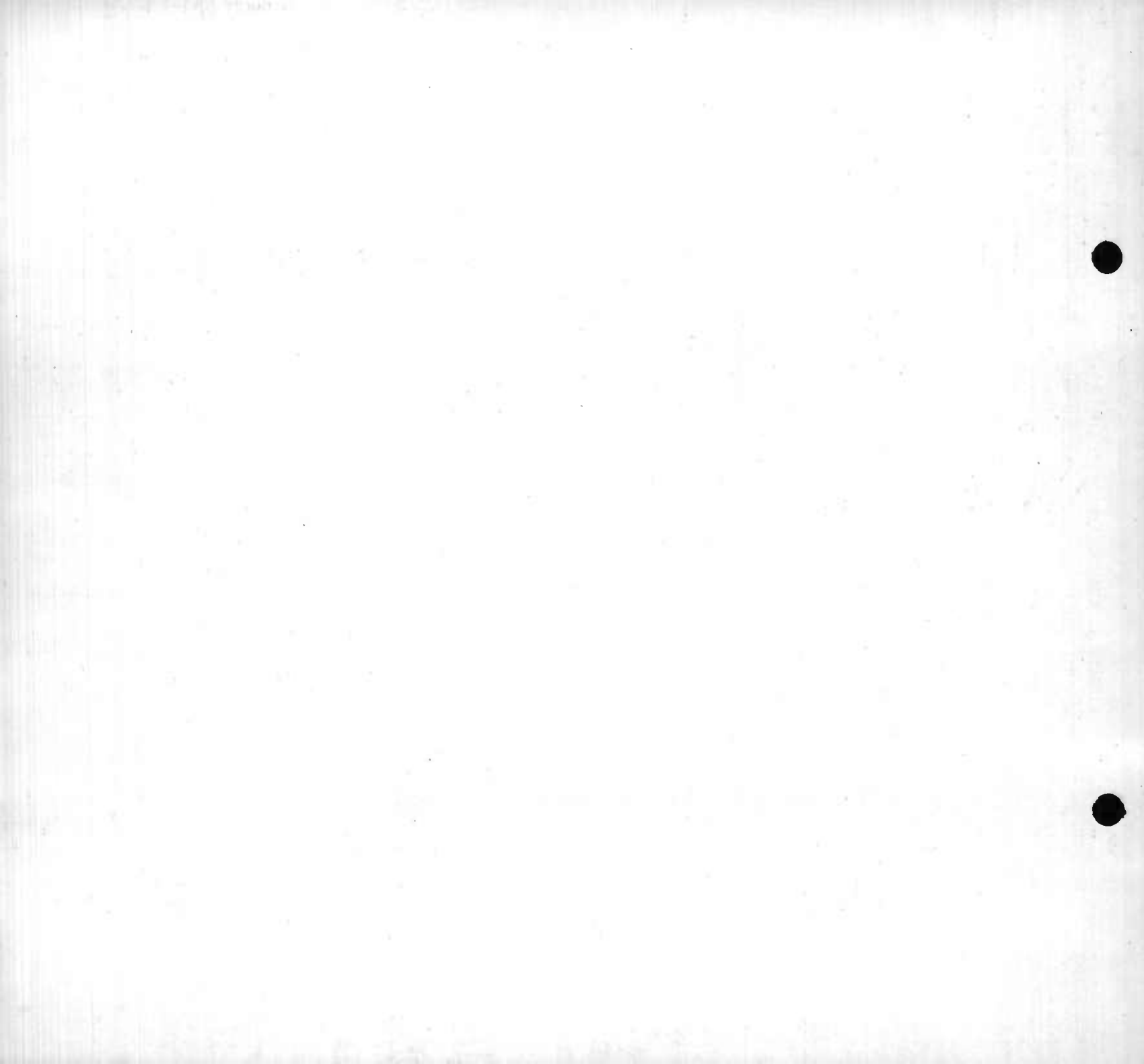
Robert E. Fairley, M.D.

Paul E. Chenoweth Jr. 3615 Chestnut Ave.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 6721				69 6721	
CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		NAOMI M. WITKOWSKI NAOMI WITKOWSKI		2. DATE AND HOUR OF DEATH 7-1-69 10:40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY md 704			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4 NORTH CHARLES GEN HOSP 28th + CHARLES BALTO 21218		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 718 S. BETHEL ST BALTIMORE md 21231					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-02-20 48	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Charles Krist CHARLES KRIST		14. MOTHER'S MAIDEN NAME Rose Griger ROSE GRI GER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-0342		17. INFORMANT Mr. Michael P. Witkowski, 718 S. Bethel St PATIENT Chair SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 136.21		CAUSE OF DEATH Carcinomatosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Ampulla of Vater (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS MONTHS	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 1-22-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA Common BILE duct		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 5-17 19 69 to 7-1 19 69, that (I) (we) last saw the deceased alive on 7-1-69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 7/2/69	
23C. PHYSICIAN'S NAME (Type) NOEL LAWSON, M.D.		23D. ADDRESS North Charles General			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE	
25D. ADDRESS					

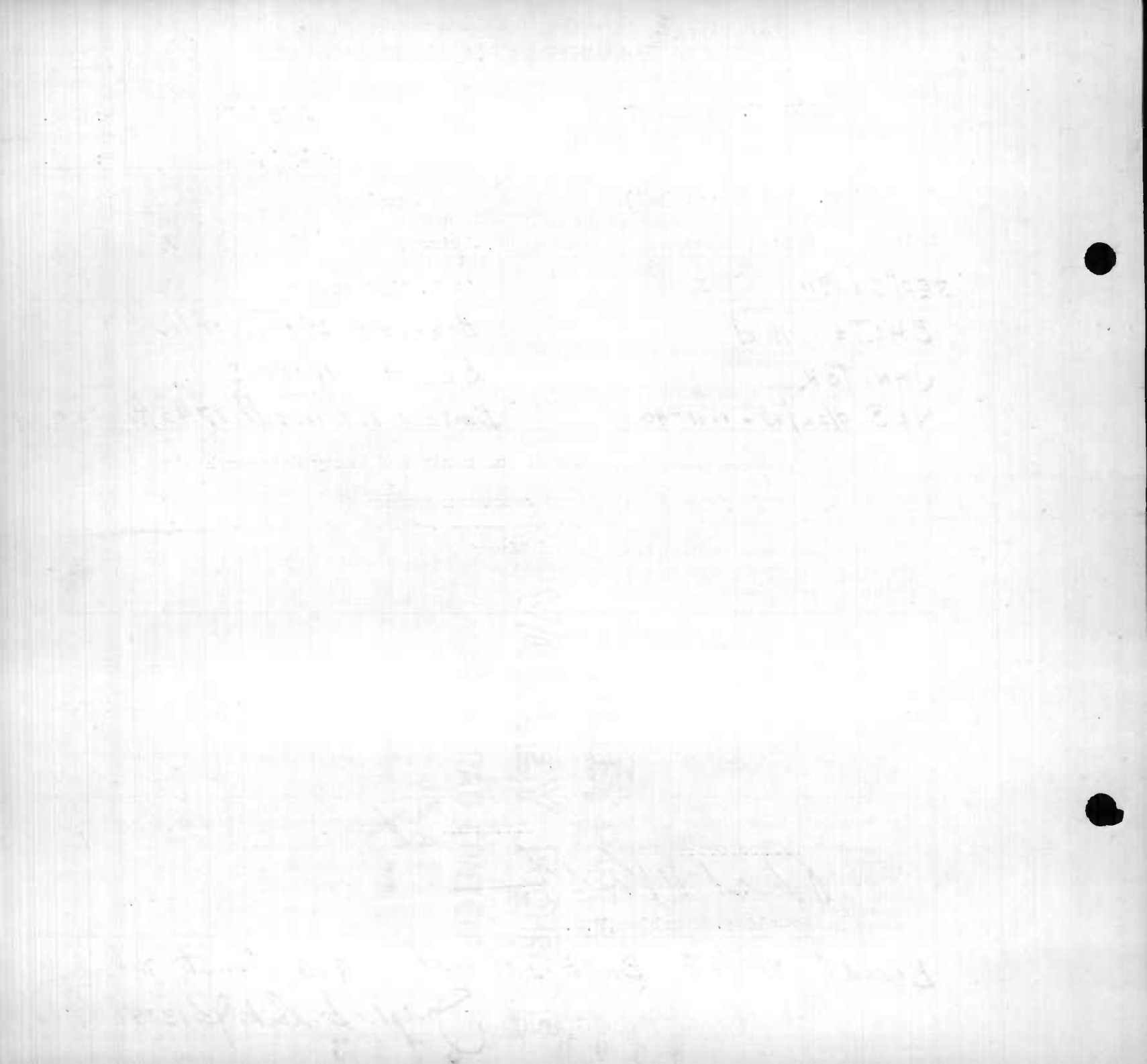


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6722

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HORACE E. WHITWORTH				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 1, 1969 9:40 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 822 E. 22nd Street (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1969 9:40 P.M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH SEPT 21, 1911				10. AGE (In years last birthday) 57		11. BIRTHPLACE (State or foreign country) BALTO. Md	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME HORACE WHITWORTH		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR	
15. MOTHER'S MAIDEN NAME ELLA NORRIS				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES 9/22/43 - 1-11-46		17. SOCIAL SECURITY NO.	
18. INFORMANT Barbara Whitworth				19. ADDRESS 1743 Homestead Ad			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 485X (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Bronchopneumonia and Fatty Metamorphosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE XXXXXXXXXXXXXXXXXXXX (B) of Liver DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/2/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/4/69		24C. NAME of CEMETERY or CREMATORY Balto National		24D. LOCATION (City, town, or county) (State) a. a. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph B. Lock		ADDRESS 1304 N. Central Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6723

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MRS. MARY DANIELS

2. DATE AND HOUR OF DEATH

7-1-69

1755 P.M.

3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BON SECOURS HOSPITAL
2025 W. BALTIMORE ST.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

BALTIMORE MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

318 N. MONROE ST. 2001

5. SEX

F

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

2-25-09

9. AGE (In years lost birthday)

59

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Disabled

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

WILLIAM ROBINSON

14. MOTHER'S MAIDEN NAME

SALLY ROBINSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

579-58-3573

17. INFORMANT

Mrs Ellameade Sullivan,

ADDRESS

same

18.

4-3-3-91

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Encephalomalacia
DUE TO, OR AS A CONSEQUENCE OF:

3 years

(B) Cerebral arteriosclerosis with
DUE TO, OR AS A CONSEQUENCE OF:

3 years

(C) Thrombosis

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6:30.69 19 to 7.1.69 19 that (I) (we) last saw the deceased alive on 7.1.69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bilal A. Qureshi

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

7.1.69

23C. PHYSICIAN'S NAME (Type)

BILAL AHMED QURESHI

23D. ADDRESS

Bon Secours Hospital Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/5/69

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION

A A County Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1969

25B. NAME OF REGISTRAR

Robert E. Gibson, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W north Ave

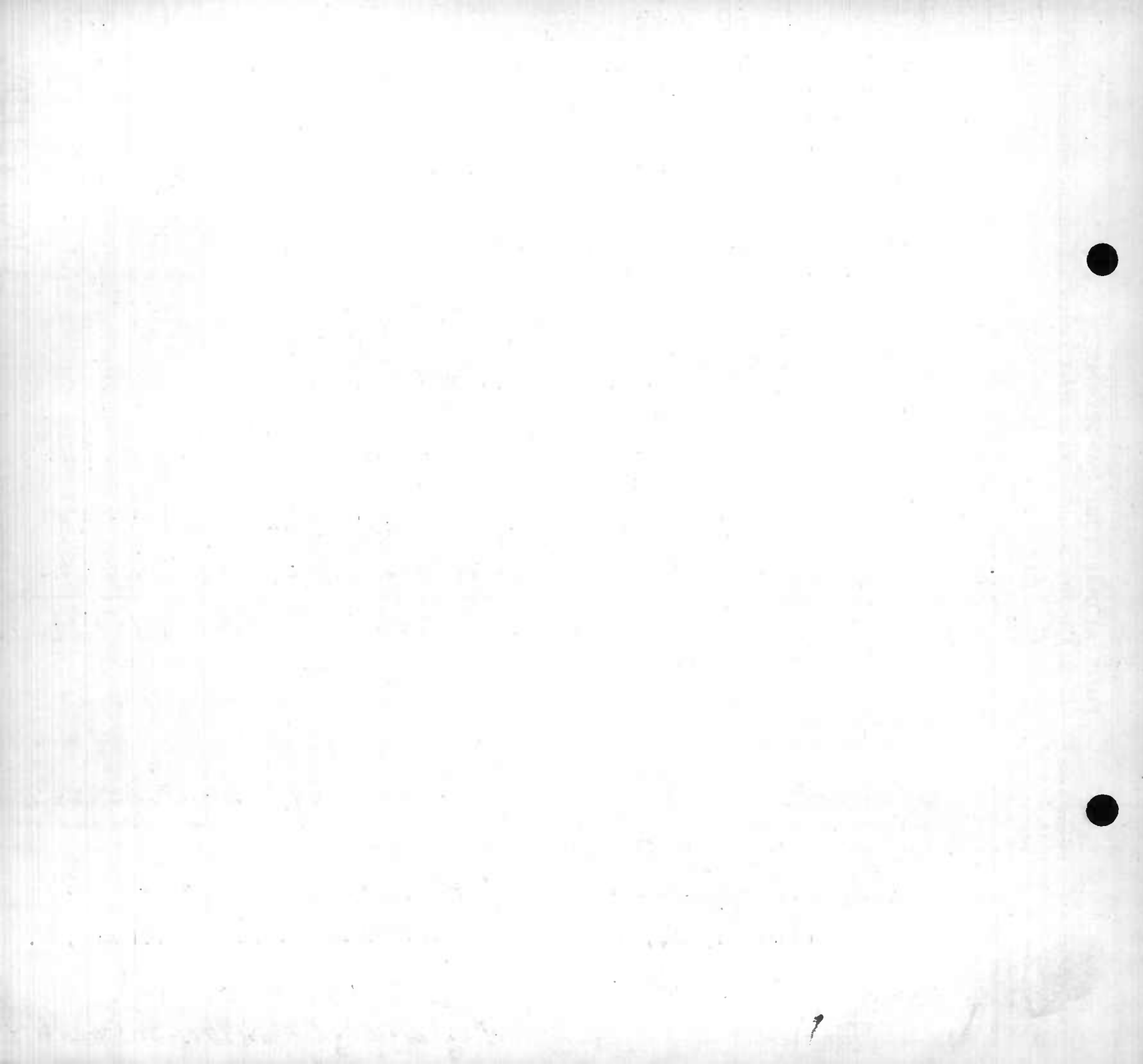
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

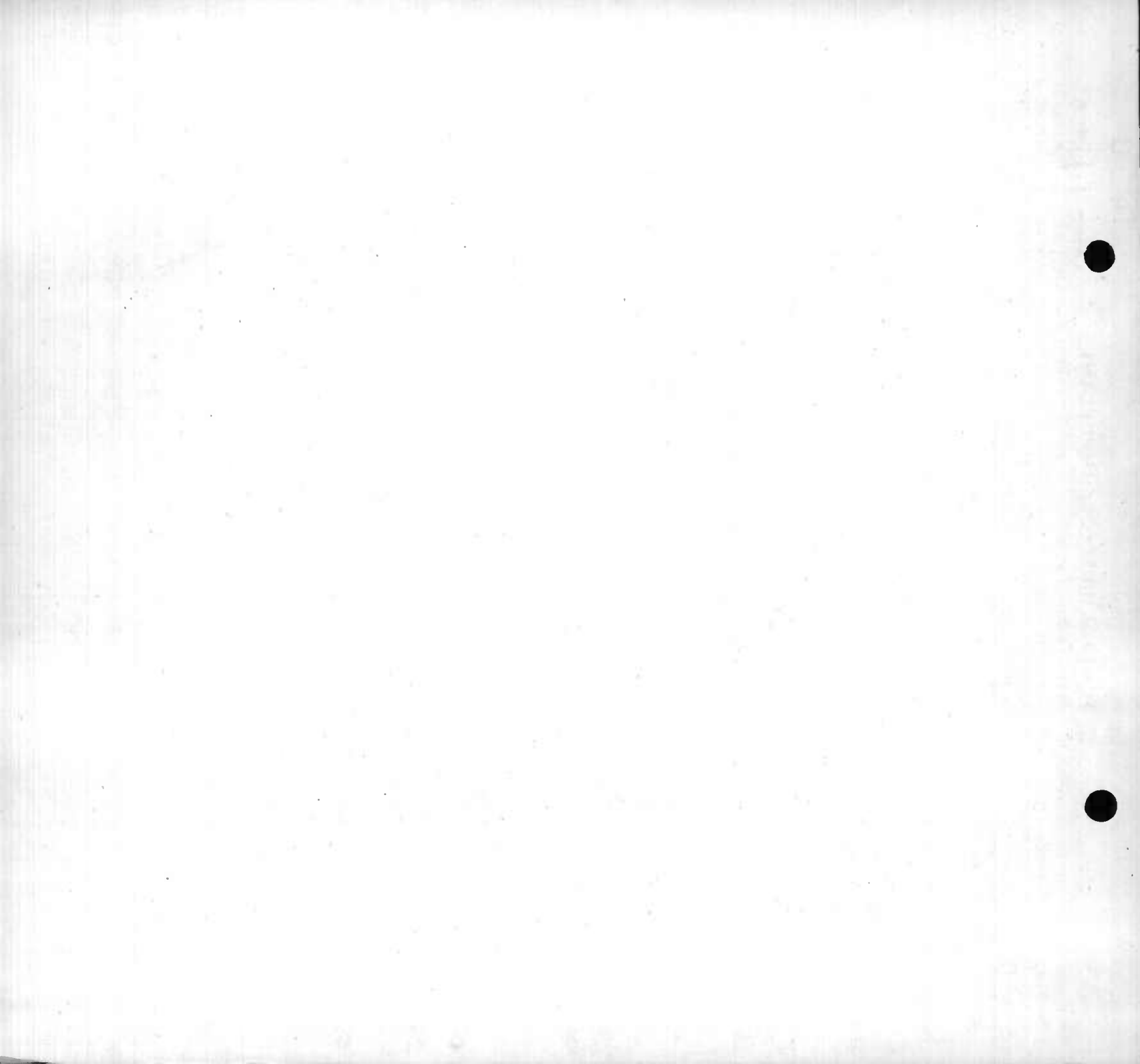
BIRTH NO. 530		BALTIMORE CITY HEALTH DEPARTMENT 69 6724 CERTIFICATE OF DEATH		REG. NO. 69 6724	
1. NAME OF DECEASED (Type or Print) <u>Hunt, Lather</u>			2. DATE AND HOUR OF DEATH <u>6/29/69</u> <u>1:00</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2765</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington Nursing Home</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2101 W. Cold Spring Lane</u>					
5. SEX <u>Female</u>	6. RACE <u>Non White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1892</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Bob Bush</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 025958</u>		17. INFORMANT <u>Chart</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>HYPOSTATIC PNEUMONIA</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL AND GENERAL ARTERIO SCLEROSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL APOPLEXY</u> (C) <u>LATE-LATENT LUES</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>YEARS</u> <u>ONE WEEK</u> <u>YEARS</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12 MAY 1969</u> to <u>29 JUNE 1969</u> , that (1) (we) last saw the deceased alive on <u>29 JUNE 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard Tyson</u>			23B. DATE SIGNED <u>6-29-69</u>		
23C. PHYSICIAN'S NAME (Type) <u>Richard Tyson, MD</u>			23D. ADDRESS <u>2320 Eutaw Place ; Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Int. Calvary Cem. A. A. Co. Inc</u>	
24D. LOCATION (City, town, or county) (State) <u>Ind</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Robert Williams</u>		25D. ADDRESS <u>1701-3h Bond St</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
69 6725 CERTIFICATE OF DEATH									
REG. NO. 69 6725									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edward Brown</i>				2. DATE AND HOUR OF DEATH <i>July 2, 1969 1: P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>1205</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>91 Montebello St. Hospital</i>					C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <i>1820 Barclay St.</i>				
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-30-1905</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Porter</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Moses Brown</i>					14. MOTHER'S MAIDEN NAME <i>Emma Williams</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown NO</i>			16. SOCIAL SECURITY NO. <i>243-09-6844</i>		17. INFORMANT <i>Hospital Chart</i>		ADDRESS <i>Gertrude Brown 1820 Barclay St.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.51 + 093.9</i>					CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic heart disease Years.</i>				
ANTECEDENT CAUSES					(B) <i>Unknown cause</i> DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) _____				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Syphilitic heart disease</i>					<i>Years.</i>				
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>5-26 1969</i> to <i>7-2 1969</i> , that (I) (we) last saw the deceased alive on <i>7-2 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Cesar J. Pellerano M.D.</i>					DEGREE <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>7-2-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellerano M.D.</i>					23D. ADDRESS <i>Montebello Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>7-7-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Darlington City Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Darlington, S.C.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 3 1969</i>			25B. NAME OF REGISTRAR <i>Robert E. Jones, M.D.</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Marshall W. Jones, Jr. 1735 Harford Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6726	
BIRTH NO. 69 6726				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MILFORD V. MILLS			2. DATE AND HOUR OF DEATH JULY 2, 1969 3:15 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD THE UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2778		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 THE UNION MEMORIAL HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH JANUARY 29, 1893		9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY HUGHES LUMBER CO.		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME VERNON MILLS			14. MOTHER'S MAIDEN NAME ANNA SEWARD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI 1917-1918			16. SOCIAL SECURITY NO. 217-07-1660		17. INFORMANT MRS. MATILDA R. MILLS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 204.11			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepato-renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic lymphatic leukemia			(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic lymphatic leukemia		(C) 48 hr.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 16 19 69 to JULY 2 19 69 that (I) (we) last saw the deceased alive on JULY 2 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Yu Sui Lit</i>			23B. DATE SIGNED JULY 2, 1969		23C. PHYSICIAN'S NAME (Type) YU SUI LIT
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/5/69		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith
24D. LOCATION (City, town, or county) Baltimore, Md.			25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		
25B. NAME OF REGISTRAR Walter E. Taylor, M.D.			25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		
25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6727
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDITH L. BONSALE		2. DATE AND HOUR OF DEATH 2 PM 7/2/69
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE (USA) Md. B. COUNTY 904		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44		C. CITY OR TOWN BALTIMORE MD 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED C&P TELEPHONE CO		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12/20/94
11. BIRTHPLACE (State or foreign country) (USA) BALTIMORE Md.		9. AGE (In years, months, and days) 74		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN P. BRANNAN		
14. MOTHER'S MAIDEN NAME MARGE GOSNELL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-03-6366A		17. INFORMANT LEIGH BONSALE, JR. (SAME)		
18. 25-0-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CADAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD Diabetes Mellitus				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3 1967 to 3 1969 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ronald M. Legum M.D.		23B. DATE SIGNED 7/2/69		23C. PHYSICIAN'S NAME (Type) RONALD M. LEGUM M.D.
23D. ADDRESS UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME OF CEMETERY or CREMATORY Greenmount
24D. LOCATION (City, town, or county) (State) BALTIMORE Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

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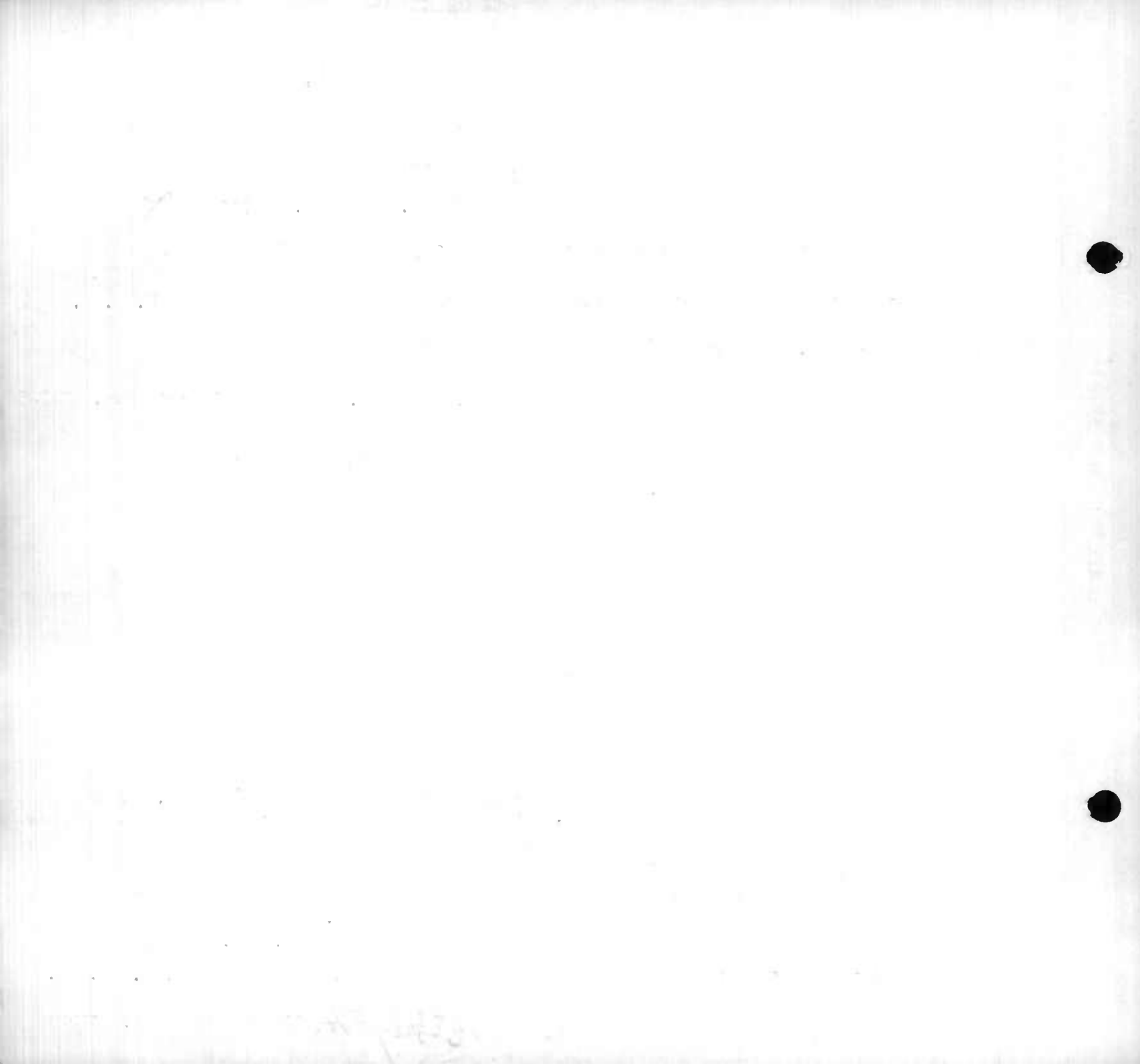
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 69 6728	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 69 6728 CERTIFICATE OF DEATH </div>							
<div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Anna Mary Schafer </div> <div> 2. DATE AND HOUR OF DEATH July 1, 1969 </div> </div>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Maryland </div> <div> B. COUNTY 2401 </div> </div>				
5. SEX Female			6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Umbrella Tipper			10B. KIND OF BUSINESS OR INDUSTRY Polan & Katz		8. DATE OF BIRTH Aug 22, 1890		
13. FATHER'S NAME Edward J. Schafer			14. MOTHER'S MAIDEN NAME Mary Neka		9. AGE (In years last birthday) 78		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Edward F. Schafer		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease			CAUSE OF DEATH Arteriosclerotic heart disease		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension			INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) Dr. [Name] attended the deceased from June 1967 to July 1, 1969 and that (2) Dr. [Name] last saw the deceased alive on July 1, 1969 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) Dr. [Name] (did not view the body after death.							
23A. SIGNATURE  Samuel Rubin					23B. DATE SIGNED 7/1/69		
23C. PHYSICIAN'S NAME (Type) Samuel Rubin					23D. ADDRESS 203 E. Patapsco Avenue Baltimore, Md. 21228		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/69		24C. NAME OF CEMETERY OR CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Ritchie Highway A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Samuel E. [Name]		25C. FUNERAL DIRECTOR McGilly FH			
					ADDRESS 237 Patapsco Ave. 21225		



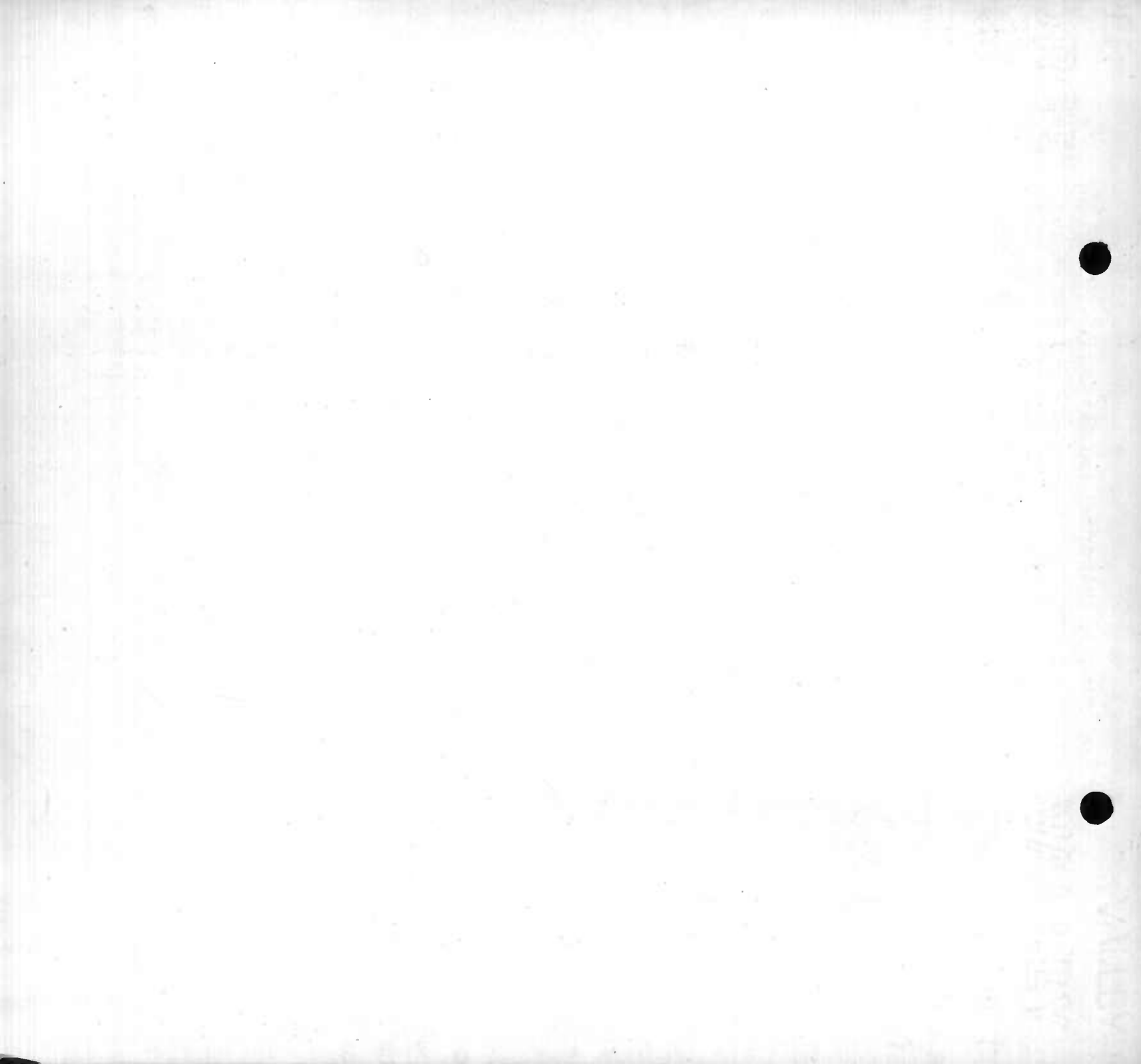
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6729 CERTIFICATE OF DEATH

REG. NO. 69 6729

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY R. VLK (Also known as Marie)		2. DATE AND HOUR OF DEATH 7/1/69 2:20 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Baltimore B. COUNTY 703			
FULL NAME OF HOSPITAL OR INSTITUTION Harbor View NCC 1213 Light ST		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Glen L. Martin Co. at home		8. DATE OF BIRTH 9/20/84 9. AGE (In years lost birthday) 84	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Vaclav Ruzicka		14. MOTHER'S MAIDEN NAME Marie Julobicka			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-14-0616		17. INFORMANT James Jirout, son, 3213 Elmora Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 485X I Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intermittent Cardiac Disease yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from May 1 19 69 to July 1 19 69 , that (H) (we) lost saw the deceased alive on July 1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. C. Plevins, M.D.		23B. DATE SIGNED July 1, 1969		23C. PHYSICIAN'S NAME (Type) A. C. PLEVINS, M.D.	
23D. ADDRESS 1309 57 Paul St Baltimore, Md 21203		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/5/69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Walter E. Gaber, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 6730				69 6730	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William F. KAMMERER</u>		2. DATE AND HOUR OF DEATH <u>30 JUNE 69</u> <u>9:50 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2731</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSP.</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4120 Parkside Drive 21206</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14 OCT 1896</u>	9. AGE (In years last birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Supt. of Carriers U.S. Govt.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Kammerer</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET DITMAR</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-44-3372</u>		17. INFORMANT ADDRESS <u>Ella C. (nee Truitt) wife, above</u>	
18. <u>562.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>SEPTICEMIA, E-I Blood</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ACUTE BIECTICOLITIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12P.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>A. BIECTICOLITIS</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>20 JUNE 1969</u> to <u>30 JUNE 1969</u> that (I) (we) last saw the deceased alive on <u>30 JUNE 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George Sabogal</u>				23B. DATE SIGNED <u>30 JUNE 69</u>	
23C. PHYSICIAN'S NAME (Type) <u>JORGE SABOGAL</u>				23D. ADDRESS <u>UNION MEMORIAL HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/3/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>R. S. E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc. 3331 Brehms Lane</u>			

JUL 3 1969



FUNERAL DIRECTOR: IMPORTANT

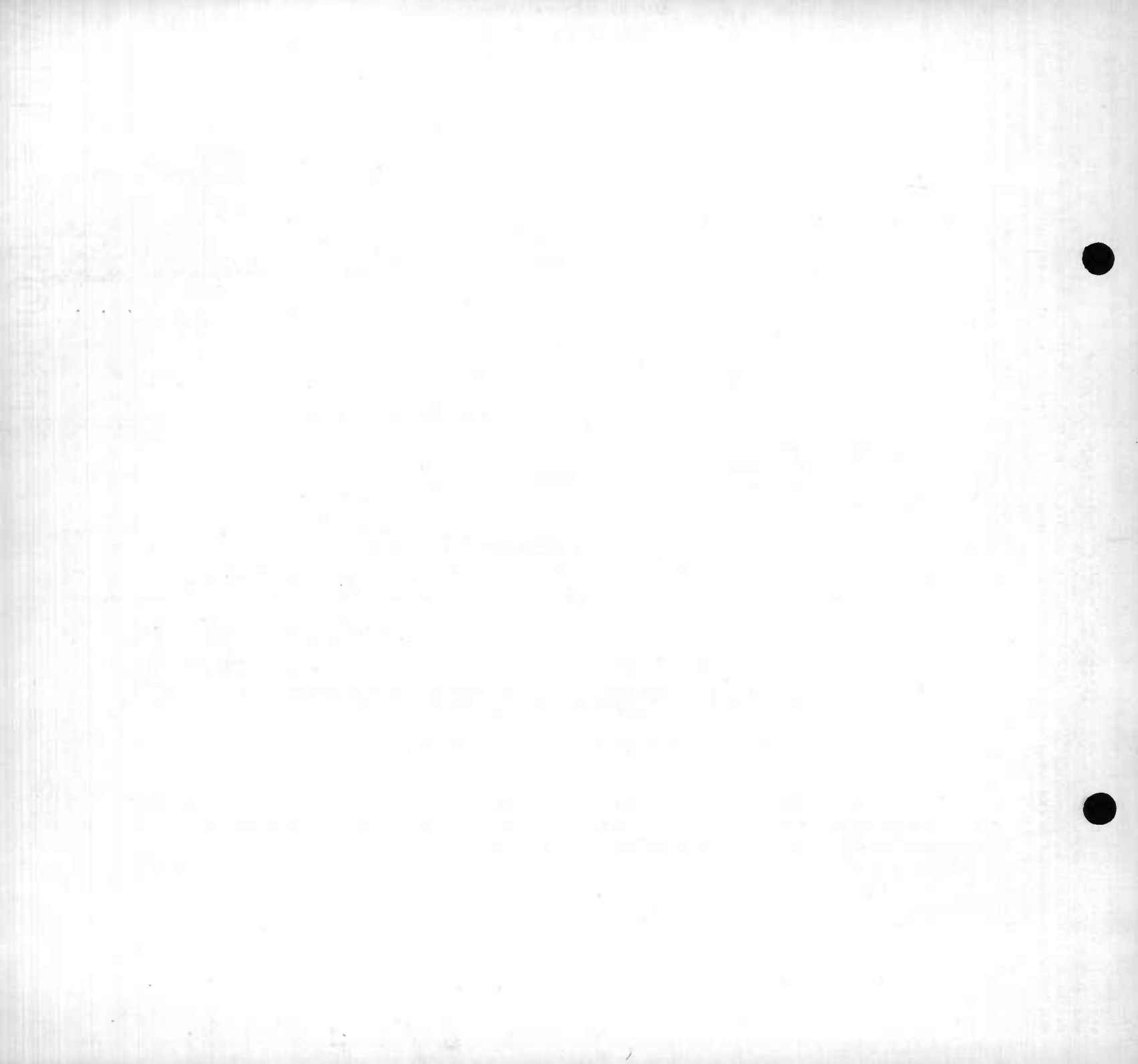
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6731

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 6731

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA S. PROCHASKA		2. DATE AND HOUR OF DEATH 6/29/69 @ 340 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 701		
FULL NAME OF HOSPITAL OR INSTITUTION 45 THE Good Samaritan Hospital			C. CITY OR TOWN BALTO. MD.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 719 N. LINWOOD AVE.		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-88	9. AGE (In years last birthday) 81 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA	
13. FATHER'S NAME Stupka			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-5363		17. INFORMANT John V. Prochaska, husband, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 593.21			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gram neg sepsis 2		2 1/2 hours
			(B) Pneumonia		2 days
			(C) Renal Failure; uremia		9 months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Atherosclerotic Cardiovascular dis.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from April 15 1969 to June 29 1969 , that (1) (we) last saw the deceased alive on June 29 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE David H. Huffman M.D.			23B. DATE SIGNED 6/29/69		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/2/69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.			25A. DATE REC'D BY HEALTH DEPT. JUL 5 1969		
25B. NAME OF REGISTRAR Robert E. Taylor M.D.			25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		
25D. ADDRESS 2800 E. Madison St.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6732

BIRTH NO. *Balto. Co., Md.*1. NAME OF DECEASED
(Type or Print)

GINA RENA TRESSLER

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

June 29, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 29, 1969

3:30 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

601

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

OCT. 22, 1968

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

78

E. STREET AND NUMBER

2906 Orleans Street

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JACK TRESSLER

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

PEGGY SPENCER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

JACK TRESSLER

ADDRESS

ABOVE

19. 269.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Malnutrition
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7/1/69

24C. NAME of CEMETERY or CREMATORY

GARDENS OF FAITH

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1969

25B. NAME OF REGISTRAR

www E. Fisher, M.D.

25C. FUNERAL DIRECTOR

J.G. CONNELLY SONS 300 MALE

ADDRESS

During 7/1/41 Forest of ...

The ...

THE ...
THE ...
THE ...

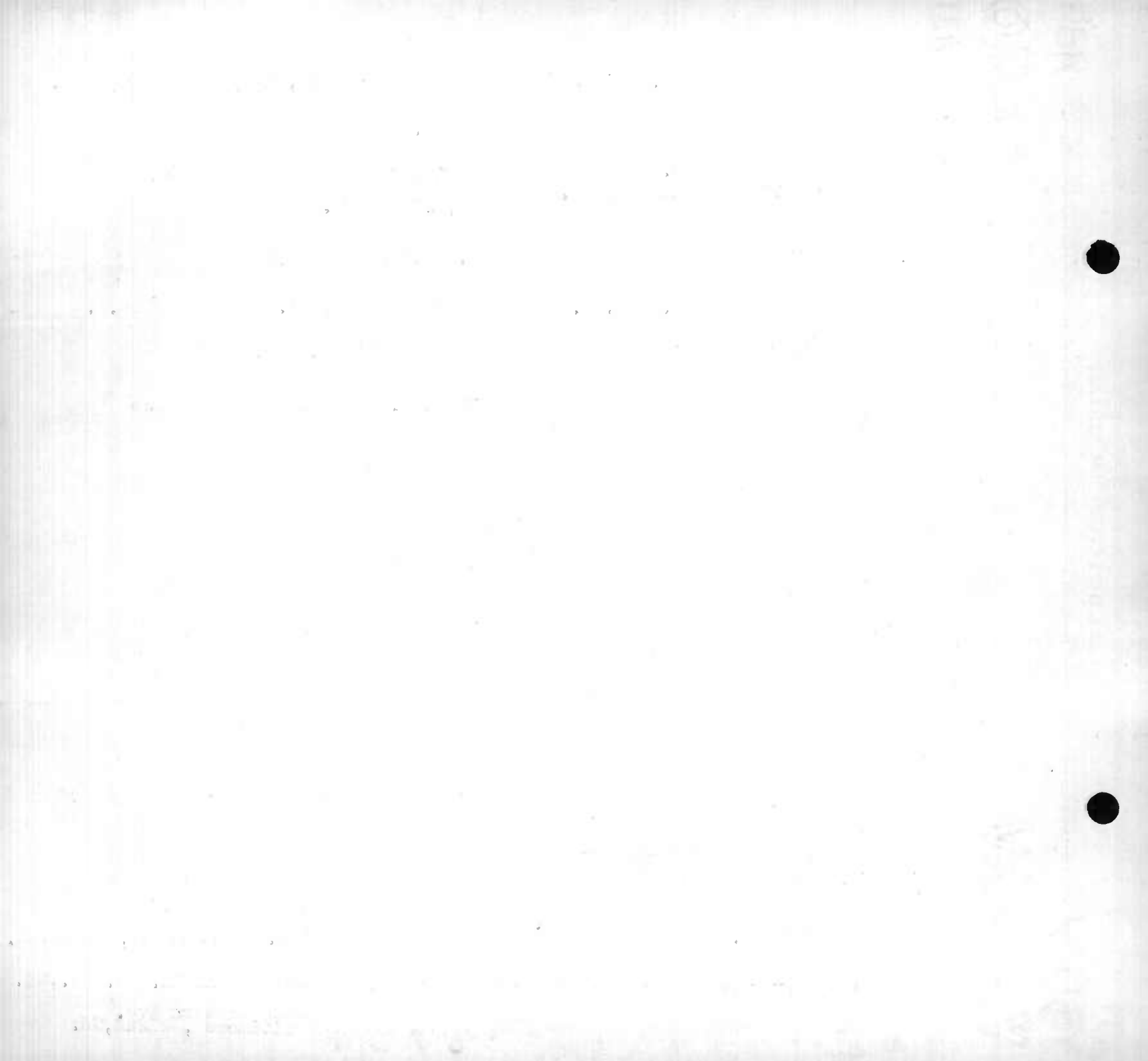
WILLIAM ...

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 6733**

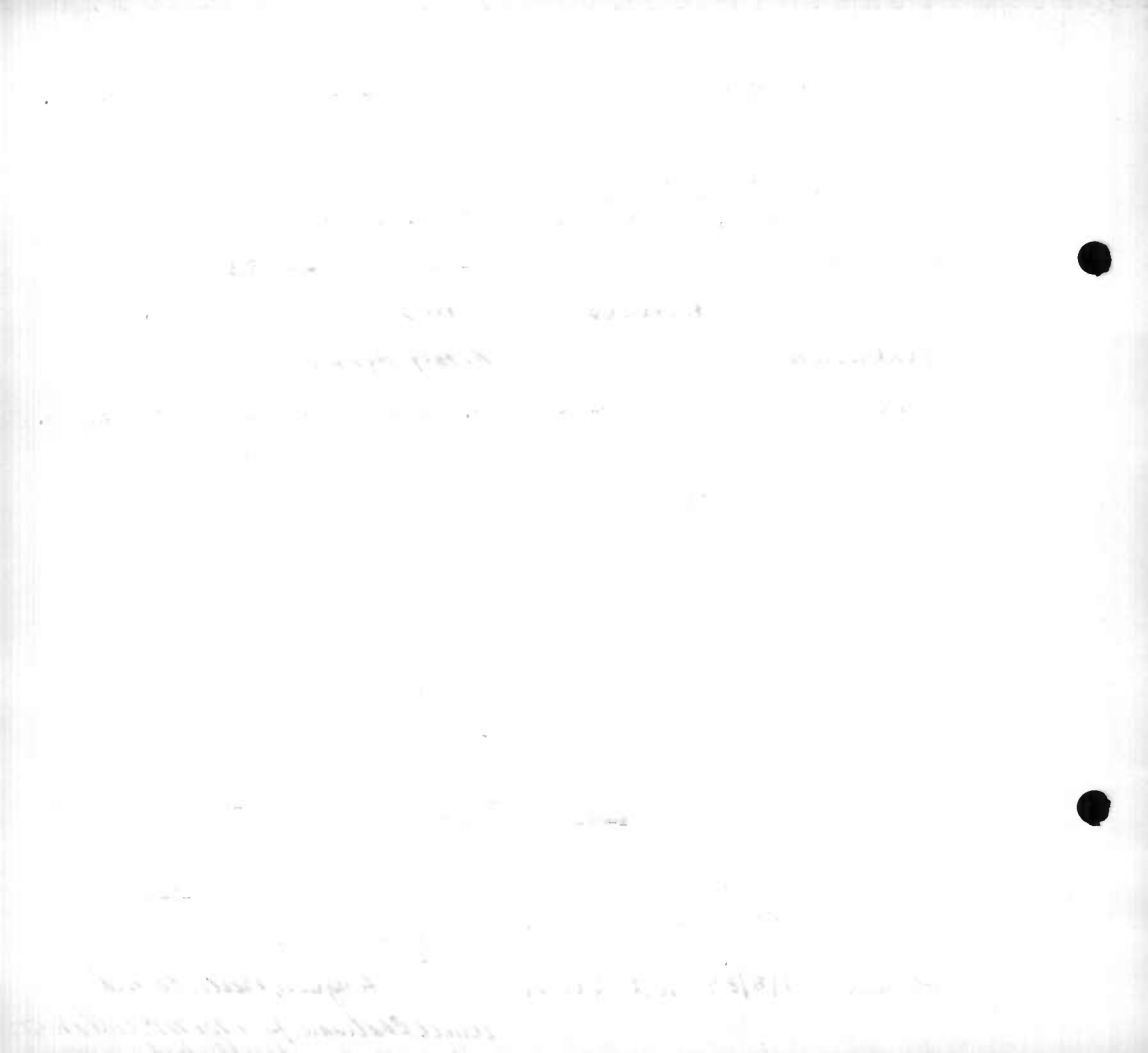
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ADAM E. ZELERS		2. DATE AND HOUR OF DEATH July 1, 1969 6:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 407 Elrino St. Baltimore, 21224, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2605 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 407 Elrino St. # 21224.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1891	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Pa. R.R. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Frank Zielski		
14. MOTHER'S MAIDEN NAME Julianna ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Albert T. Zellers		
18. ADDRESS Same			19. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C.V.A. Rheumatoid arthritis advanced			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). anemia & Prostatic hypertrophy					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 1964 to July 1, 1969 , that (I) (we) last saw the deceased alive on Jul 1, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rafael A. Santayana			23B. DATE SIGNED July 2-69		
23C. PHYSICIAN'S NAME (Type) RAFAEL A. SANTAYANA			23D. ADDRESS 6010 Eastern Ave., Baltimore, 21224, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-69.		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Ba. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969			
25B. NAME OF REGISTRAR James E. Zellers, M.D.		25C. FUNERAL DIRECTOR 6224 Eastern Ave. Baltimore, 21224, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

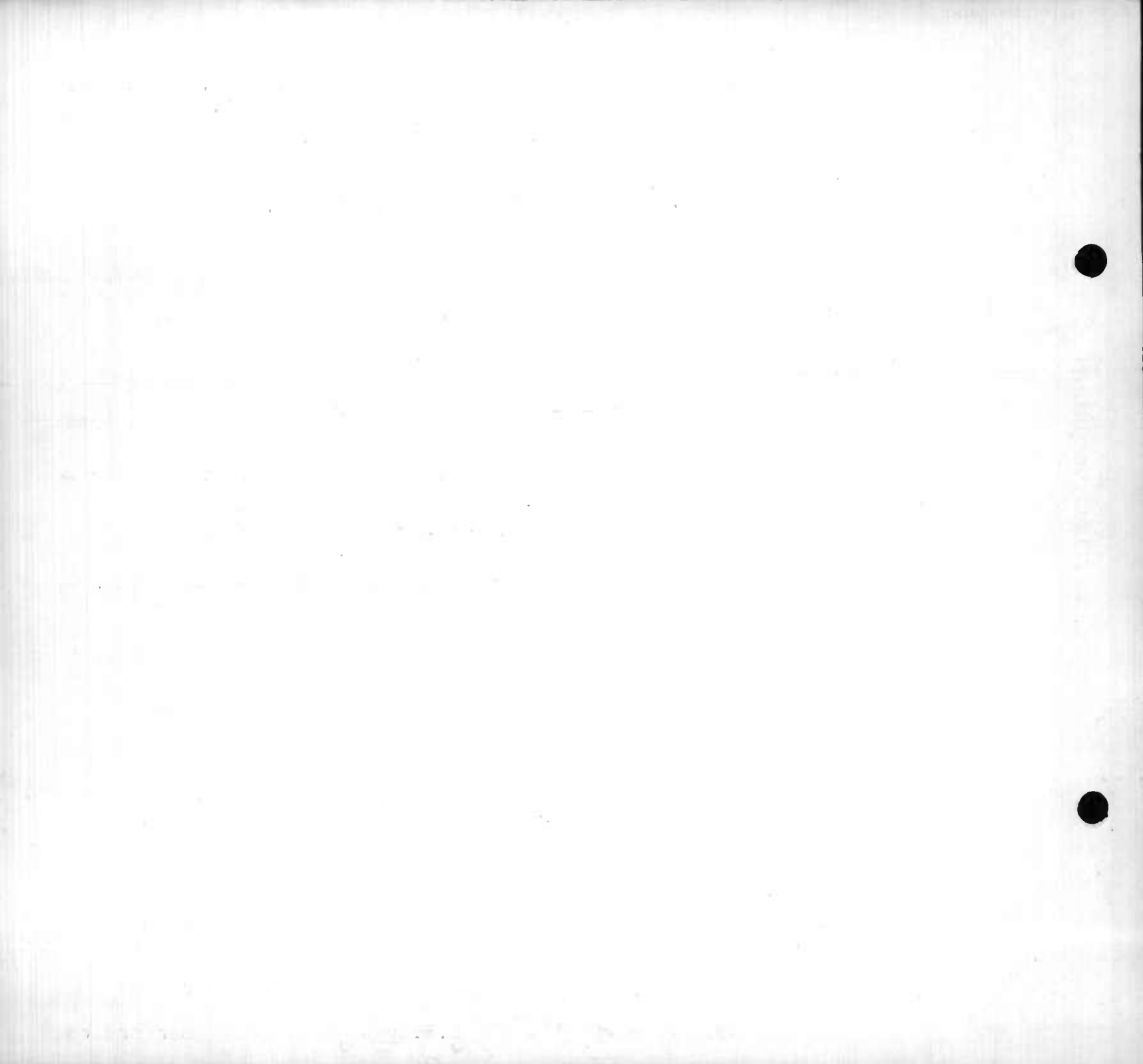
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6734	
BIRTH NO.		69 6734		69 6734	
1. NAME OF DECEASED (Type or Print) <u>Henry Brice</u>			2. DATE AND HOUR OF DEATH <u>6-30-69</u> <u>10:00</u> p. m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1501</u>		
C. CITY OR TOWN <u>Baltimore</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1328 N. Fremont Avenue</u>					
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-85</u>	9. AGE (In years last birthday) <u>66</u> <u>83</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>
11. BIRTHPLACE (State or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>MARY MYERS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>215-10-1090</u>		
17. INFORMANT <u>Mr. Joe Daniel Grandson</u>			ADDRESS <u>5021 Mid Wood Ave.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal Failure</u> <u>Uremia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>6-30-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> <u>1969</u> to <u>6-30</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>6-30</u> <u>1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gregorio Tengco</u>				23B. DATE SIGNED <u>7-1-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>GREGORIO TENGCO MD.</u>				23D. ADDRESS <u>1514 Division Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Zion</u>	
24D. LOCATION (City, town, or county) (State) <u>Longview, Balti. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1969</u>		25B. NAME OF REGISTRAR <u>Wm. C. Chapman, Jr.</u>	
25C. FUNERAL DIRECTOR <u>Wm. C. Chapman, Jr.</u>		ADDRESS <u>1701 Mt. Cullah St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

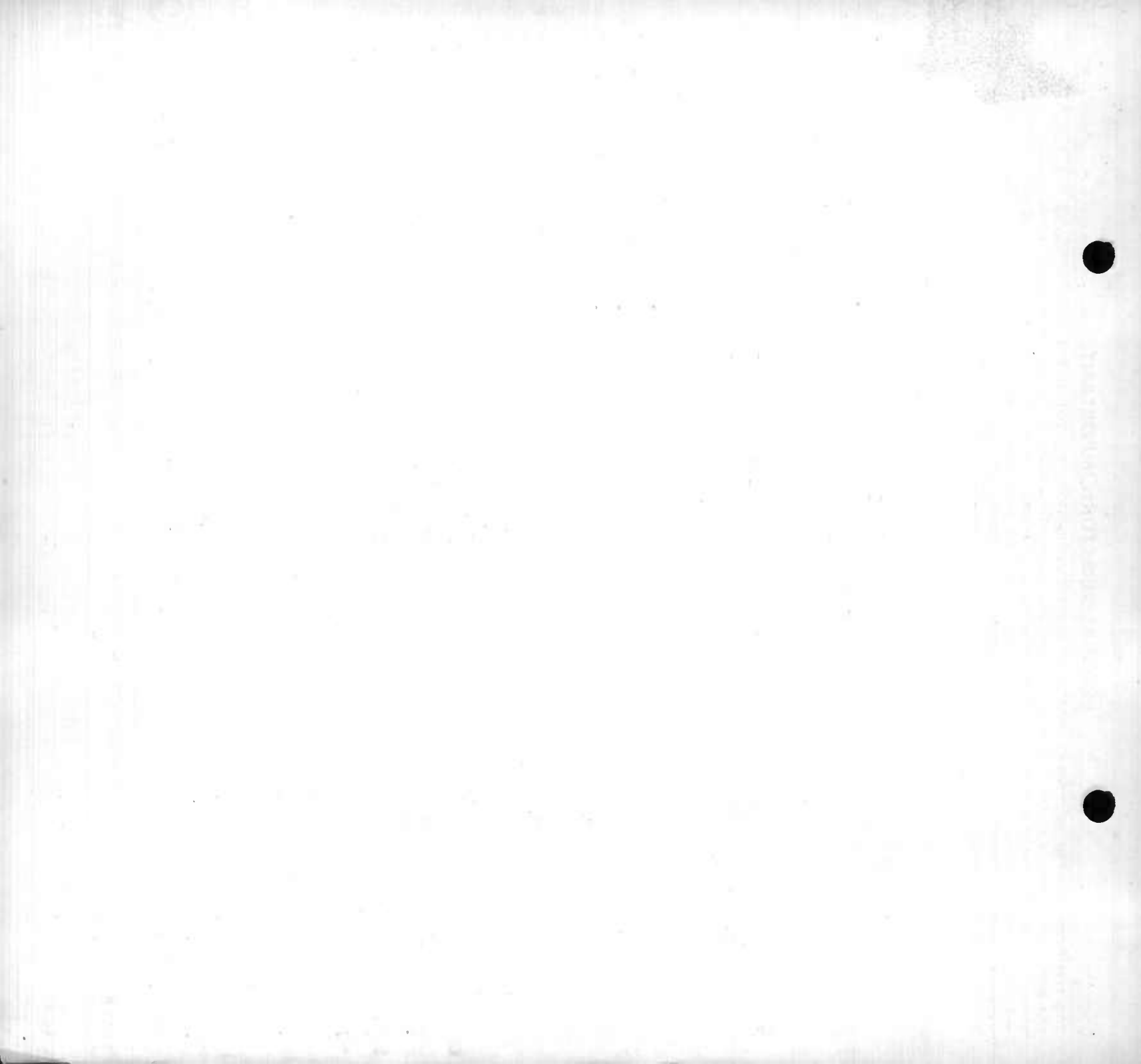
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6735
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WICK, ANNA		2. DATE AND HOUR OF DEATH 6/30/69 9:30 PM. 9:30 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived ^{at} institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90 BOLT ON HILL NURSING 1400 John STREET.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/15/89		9. AGE (In years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Wick			14. MOTHER'S MAIDEN NAME Elizabeth Davidson		12. CITIZEN OF WHAT COUNTRY? USA
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-01-4131		17. INFORMANT Family records
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE recent cerebral thrombosis years (B) arterial embolism to heart years (C) generalized arteriosclerosis years		
19A. DATE OF OPERATION 6/23/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/23 1969 to 6/30 1969 , that (I) (we) last saw the deceased alive on 6/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. MACHT MD				23B. DATE SIGNED 7/1/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD				23D. ADDRESS 2 E Red St Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/69		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State) Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR James E. Taylor, M.D.		25C. FUNERAL DIRECTOR G. F. EVANS & SON 8802 Harford road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

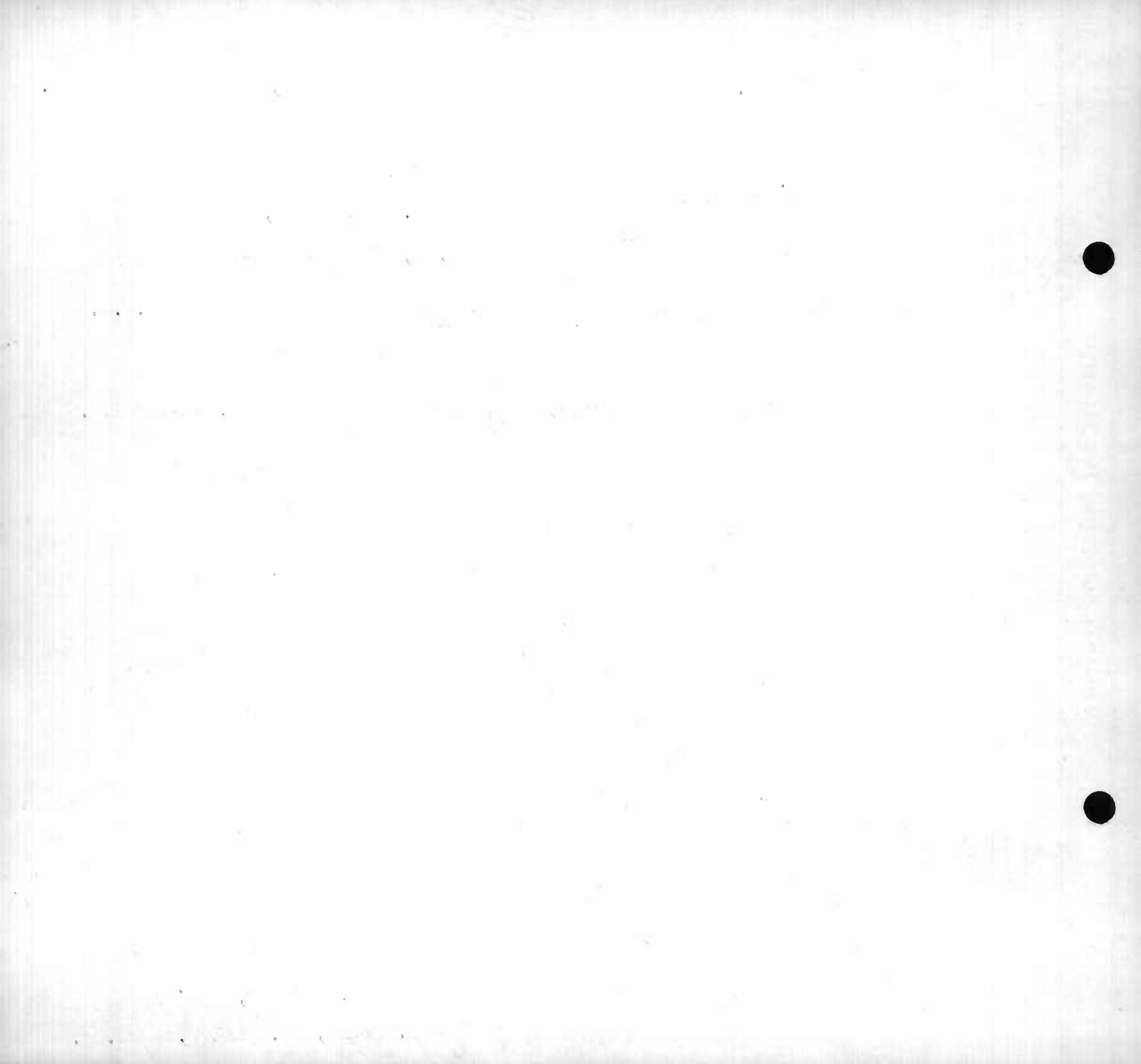
BIRTH NO. 15-260 69 6736				BALTIMORE CITY HEALTH DEPT.		REG. NO. 69 6736	
1. NAME OF DECEASED (Type or Print) KAISER, Thomas				2. DATE AND HOUR OF DEATH 6/29/1969 3:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland 21224				A. STATE Maryland		B. COUNTY 2610	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 103 S. Clinton St. 21224			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-96		9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oilman (Oiler)		10B. KIND OF BUSINESS OR INDUSTRY Penn. R.R.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kaiser				14. MOTHER'S MAIDEN NAME Elizabeth Roth			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 71707-7277		17. INFORMANT BCH Recprds: 4940 Eastern Ave. Baltimore, Maryland 21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 6/14/1969 to 6/29/1969, that (I) (we) lost saw the deceased olive on 6/29/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] 23B. DATE SIGNED June 29, 1969 23C. PHYSICIAN'S NAME (Type) Ruiz-Moro 23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. Baltimore City Hospitals 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/2/69 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Frederick C. Lennert</u>		2. DATE AND HOUR OF DEATH <u>June 30, 1969</u> <u>11 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Fayette Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>602</u>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan. 27, 1876</u>		9. AGE (In years last birthday) <u>93</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired (Maintenance man) national Enamel Co. Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Lennert</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-03-3086</u>	
17. INFORMANT <u>Florence Lennert</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive Heart Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Vascular Disease</u> <u>Dehydration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 26 - 1969</u> to <u>June 30 - 1969</u> , that (I) (we) last saw the deceased alive on <u>June 30 - 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Wm. G. Geyer</u>		23B. DATE SIGNED <u>July 1 - 69</u>		23C. PHYSICIAN'S NAME (Type) <u>WM. G. GEYER</u>	
23D. ADDRESS <u>156 N. Mictorlie</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>7/3/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1969</u>		25B. NAME OF REGISTRAR <u>John A. Morgan, Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Balto. St.</u>	

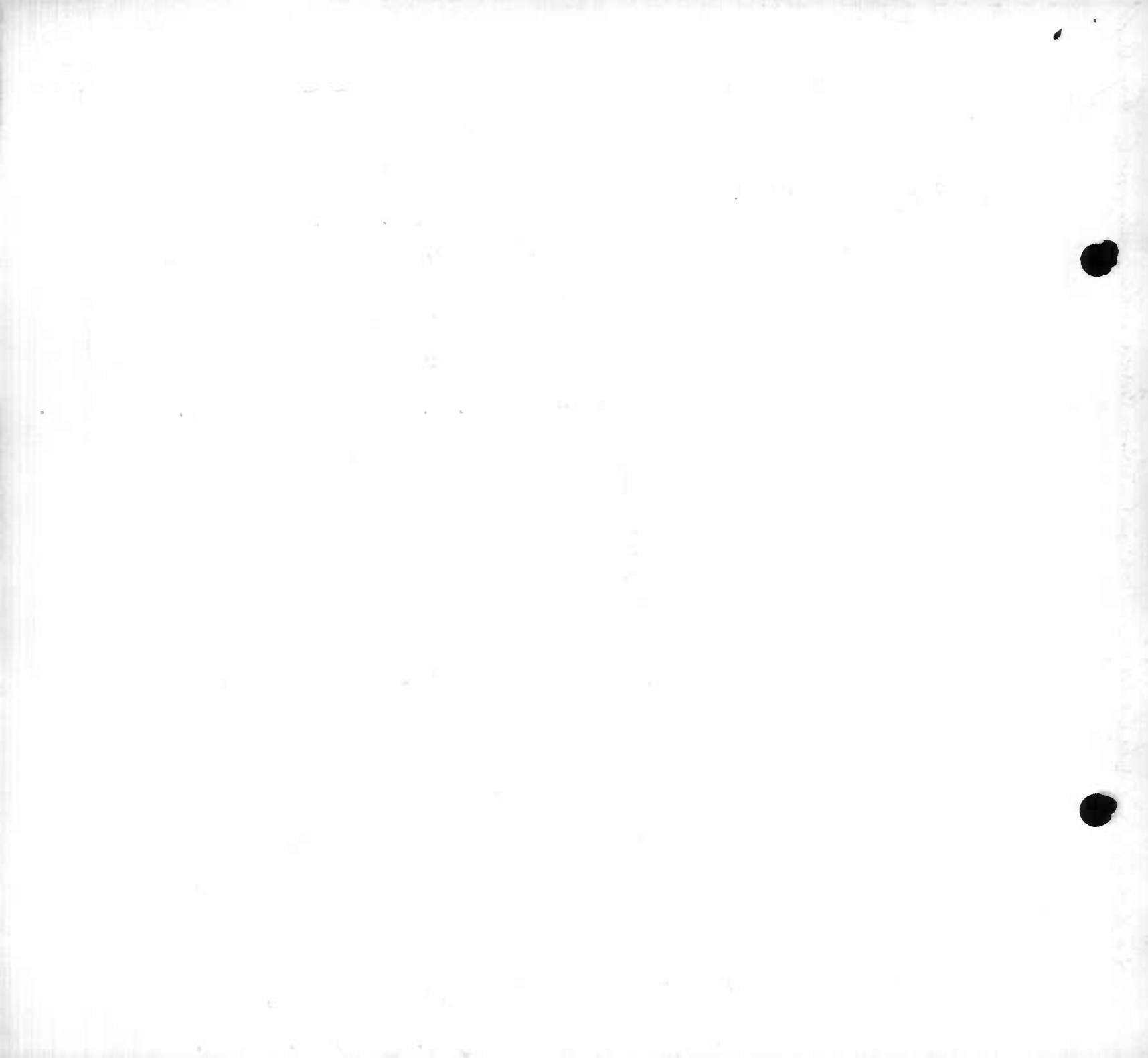


Death Certificate must be countersigned by CM.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600		69	6738	BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	69	6738
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
				Thomas Barry		6-30-69 4:25 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE & COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md		2712		
37 Mercy Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER 5512 N. Charles St				
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/'08	9. AGE (in years last birthday) 67	10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman				10B. KIND OF BUSINESS OR INDUSTRY Union Lincoln		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Barry				14. MOTHER'S MAIDEN NAME Matty Kane				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes				16. SOCIAL SECURITY NO. 27-07-1835		17. INFORMANT Mrs. C. Edward Jones 5512 N. Charles St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia - bronche				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Subdural hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION 6-20-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5512 N. Charles St. 2712				
21D. TIME OF INJURY (Approx.) 6-20-69		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? fall				
22. I certify that (I) (this hospital) attended the deceased from June 22 1969 to June 30 1969 that (X) (we) last saw the deceased alive on June 30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 4:25 P.M.				23A. SIGNATURE J. Sheldon Eastland		23B. DATE SIGNED 7/1/69		
23C. PHYSICIAN'S NAME (Type) J. Sheldon Eastland		23D. ADDRESS Med. Ctr. Bldg. Baltimore Md						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/69		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Wm. E. Taylor, M.D.		25C. FUNERAL DIRECTOR John P. Moran, Inc.		ADDRESS 3000 E. Baltimore St		

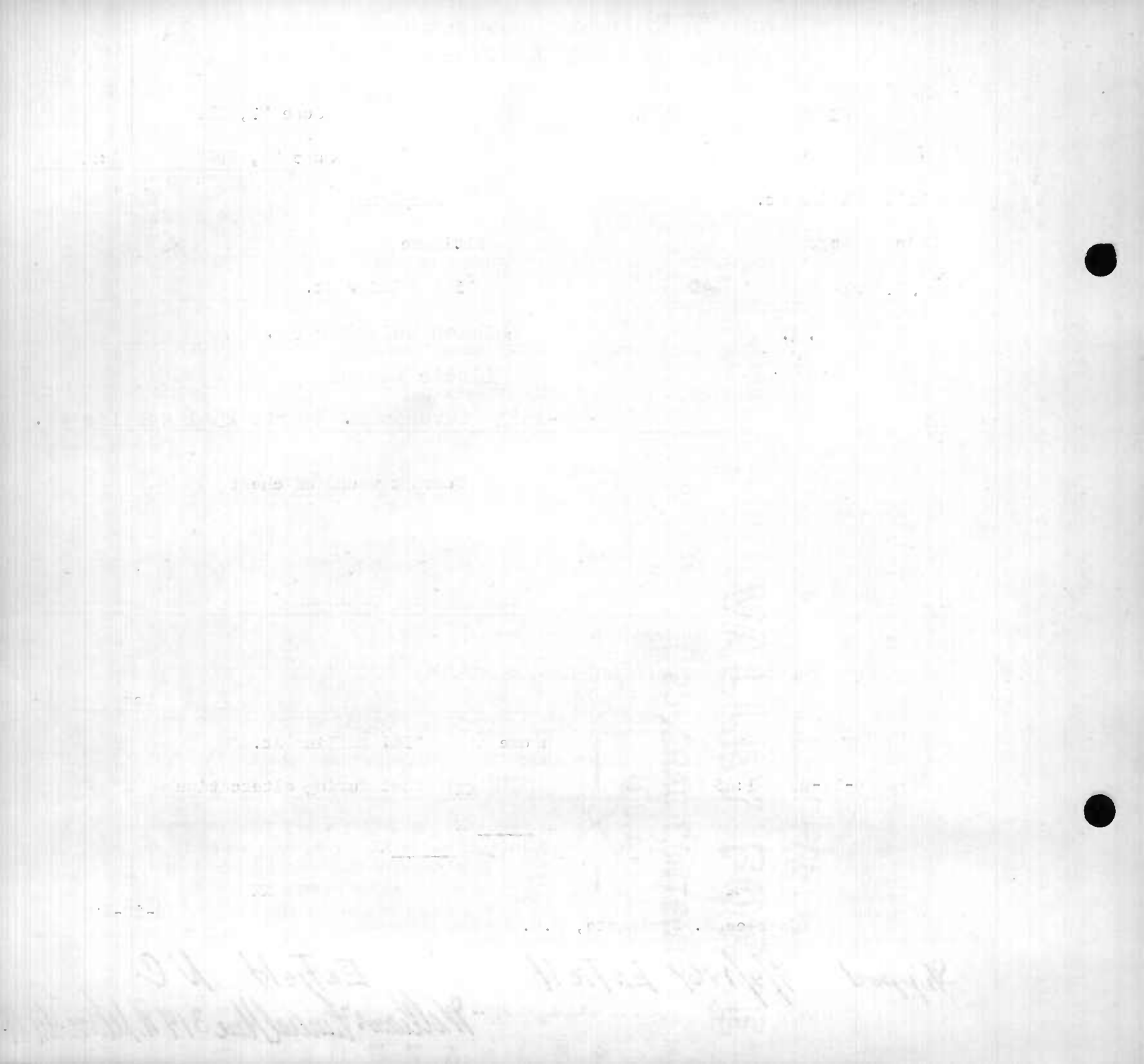


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SIMON WHITAKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 28, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2541 Hollins St.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1969 1:55 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 1, 1928		10. AGE (In years lost birthday) 40 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Enfield N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Simmon Whitaker Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Lizzie Payton		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 242-40-2881		18. INFORMANT ADDRESS Luvenia M. Harris 2541 Hollins St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) E9651X Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2541 Hollins St. 2004		22F. HOW DID INJURY OCCUR? Shot during altercation	
22D. TIME OF INJURY (APPROX.) 6-28-69 1:45 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) DATE SIGNED 6-28-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 7/4/1969	
24C. NAME OF CEMETERY or CREMATORY Enfield		24D. LOCATION (City, town, or county) (State) Enfield N.C.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Charles E. Sauer, M.D.	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schuyler St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6740 CERTIFICATE OF DEATH X REG. NO. 69 6740

BIRTH NO.		1. NAME OF DECEASED (Type in Print) MADEJ, JOSEPH ANDREW		2. DATE AND HOUR OF DEATH JUNE 30, 1969 10:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION WILKENS & CATON AVENUES BALTIMORE MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL CO. 5200		
5. SEX MALE			6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRON WORK		10B. KIND OF BUSINESS OR INDUSTRY SHIPBLDG.		8. DATE OF BIRTH 01 21 15	9. AGE (In years last birthday) 54
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MADEJ			14. MOTHER'S MAIDEN NAME (KACALA) JULIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 01 2448		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I pneumonia Mesothelioma II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MAY 19, 1969 to JUNE 30, 1969 that (X) (we) last saw the deceased alive on JUNE 30, 1969 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED JULY 1, 1969	
23C. PHYSICIAN'S NAME (Type) DR. S. QUIROZ		23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION Balto. 21225 Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969			
25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR John H. Maher			
25D. ADDRESS 4200 Pennington Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 6741	REG. NO.
BIRTH NO. 69-11634 69 6741		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Baby Girl of Brenda Gregg		7/2/69		4:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3420 Auchentoroly Terrace			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/69	9. AGE (In years last birthday) 2	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Brenda T. Gregg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 7-5-6-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardioresp arrest (B) multiple cong. anomalies DUE TO, OR AS A CONSEQUENCE OF: and seizures. (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/30 19 69 to 7/2 19 69 that (I) last saw the deceased alive on 7/2 19 69 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view the body after death.					
23A. SIGNATURE Stephen E. Barnett		23B. DATE SIGNED 7-2-69		23C. PHYSICIAN'S NAME (Type) Stephen E. Barnett, M.D.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/2/69		24C. NAME OF CEMETERY OR CREMATORY The Johns Hopkins Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
				24D. LOCATION (City, town, or county) (State) 601 N. Broadway, Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL	



P-626

69 6742 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6742

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES A. PARKER

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

South Balto. General Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 1, 1969 8:20 a.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1605

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1-30-1904

10. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2417 Calverton Heights Rd.

11. BIRTHPLACE (State or foreign country)

Heathville, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unk.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

Jarka Corp.

15. MOTHER'S MAIDEN NAME

Louise Kenner

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

215-09-3271

18. INFORMANT

Mrs. Ruth Kelly

ADDRESS

2605 Dension St.

19. 412.12

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

July 1, 1969

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-5-69

24C. NAME OF CEMETERY or CREMATORY

Zion Bapt. Ch. Cem.

24D. LOCATION (City, town, or county) (State)

Lottsburg, Virginia

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

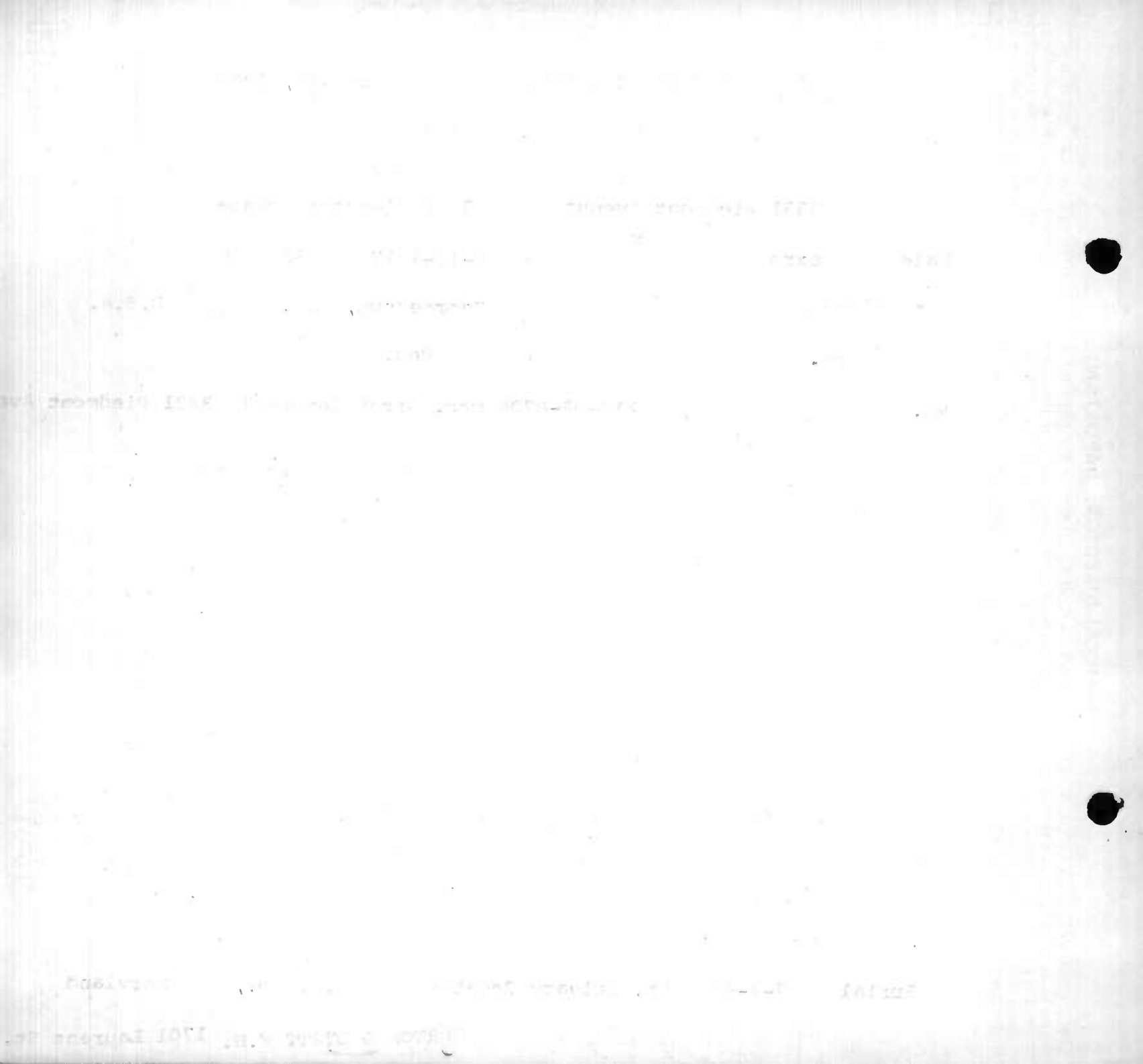
No. 215-00-3271 Mrs. Ruth Kelly 2602 Denison St.
 Retired Jarka Corp. Louise Kennel
 Westville, Virginia U.S.A. Unk.
 1-30-1904 65

Mortal 7-2-68 Zion Bapt. Ch. Cem. Lottsburg, Virginia
 MORTON & DYETT P.M. 1701 Lawrence St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
69 6743					REG. NO. 69 6743				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) JOHN FRANKLIN CAMPBELL					2. DATE AND HOUR OF DEATH June 29, 1969				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1537				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3331 Piedmont Avenue					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 3331 Piedmont Avenue				
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1917	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgetown, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unk.			14. MOTHER'S MAIDEN NAME Unk.						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 217-05-8706		17. INFORMANT Mrs. Sarah Campbell				ADDRESS 3331 Piedmont Ave
18. CAUSE OF DEATH 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/20 1967 to 6/29 1969 , that (I) (we) last saw the deceased alive on 6/20 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Emerson R. Julian M.D.					23B. DATE SIGNED 7/2/69			23C. PHYSICIAN'S NAME (Type) EMERSON R. JULIAN	
23D. ADDRESS 7329 Church Avenue									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-69		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON S. DYETT F.H. 1701 Laurens St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6741

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROSA BELL McRAE		July 1, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		1604	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		911 N. Appleton Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2-1-1897	72	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Dillon, South Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John D. Allen		Mary L. McCoy		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No.				Mrs. Rosa Faircloth 915 N. Appleton St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 days	
ANTECEDENT CAUSES		(B) Anterior sclerotic Horn Disease		2 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 1, 1969 to July 1, 1969, that (I) (we) lost saw the deceased alive on 7-1-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
G. Franklin Phillips M.D.				7/2/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
G. Franklin Phillips M.D.				558 McNeen St. Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-6-69		Bethel Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 3 1969		Robert E. Farber, R.D.		MORTON & DYETT F.H.	
				ADDRESS	
				1701 Laurens St.	

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FUNERAL DIRECTOR: IMPORTANT

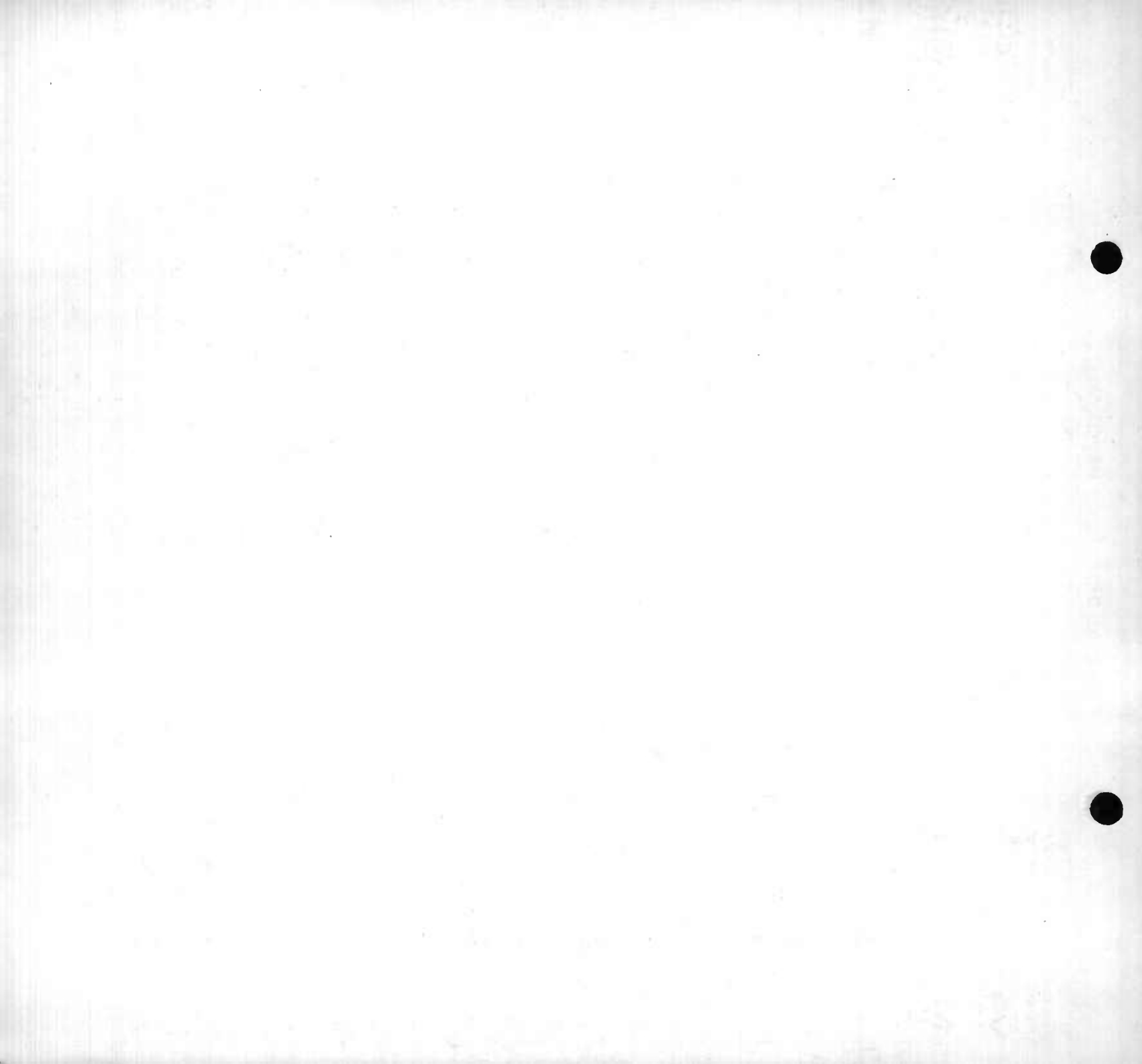
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6745	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Smith, Ralph</i>			2. DATE AND HOUR OF DEATH <i>6-23-69 145 A M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Harford Co.</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Pleasant Mann Nursing Home</i>			C. CITY OR TOWN <i>Darlington Md</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <i>Rt 1 Box 84</i>					
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-7-1899</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Mo Co</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>William Thomas Smith</i>			14. MOTHER'S MAIDEN NAME <i>Anne Tucker</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Carrie Smith</i> ADDRESS <i>MD Darlington</i>	
18. <i>1899 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma, Bladder</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>Jan '69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma Bladder</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-12-1969</i> to <i>6-23-1969</i> , that (I) (we) lost saw the deceased alive on <i>6-17-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frank G. Kuehn MD</i> DEGREE				23B. DATE SIGNED <i>6/23/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>FRANK G. KUEHN MD</i> DEGREE		23D. ADDRESS <i>721 Med Arts Bldg, Balto 1 Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>6-26-69</i>	24C. NAME OF CEMETERY or CREMATORY <i>Cedar Church Cem Darlington, H2 Md</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 3 1969</i>		25B. NAME OF REGISTRAR <i>George W Tittle</i>		25C. FUNERAL DIRECTOR ADDRESS <i>BEL AIR MD</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

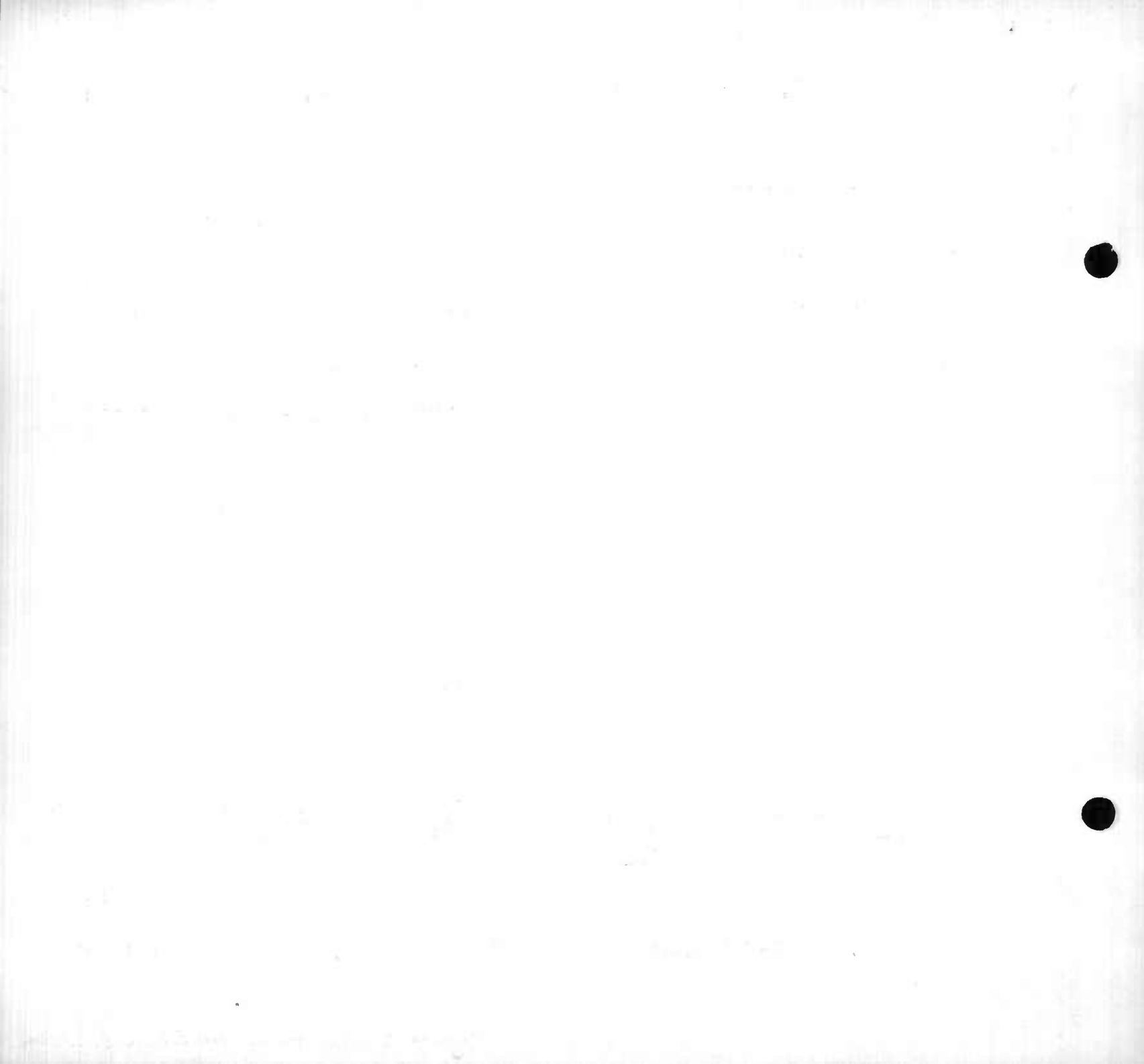
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6746	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Martha A. Young		2. DATE AND HOUR OF DEATH 7-4-69 5:30 ^{PM}			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Ashburton House 3520 N. Hilton Rd.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1538 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3401 W. Forest Pl. Apt			
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1884 9. AGE (In years) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Watkins			
14. MOTHER'S MAIDEN NAME Elizabeth Hughes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216-28-3592		17. INFORMANT ANGELA GRAY ADDRESS 3401 W. Forest Pl.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis, generalized		DUE TO, OR AS A CONSEQUENCE OF: 2 1/2 yrs.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/3/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 19, 1966 to July 1, 1969 that (I) (we) last saw the deceased alive on July 1, 1969 and that in (my) (our) opinion death occurred on the date July 1, 1969 and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Gilbert E. Rudman, M.D. DEGREE				23B. DATE SIGNED 7/5/69	
23C. PHYSICIAN'S NAME (Type) Gilbert Rudman DEGREE				23D. ADDRESS 4701 Liberty Hgts	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Balto. MD		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969 25B. NAME OF REGISTRAR Robert E. Gaber, M.D. 25C. FUNERAL DIRECTOR Joseph B. Locks ADDRESS 1304 N. Central St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6747		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6747	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROSS, BLANCHE PEARL		JULY 2, 1969 7:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. AGE (In years lost birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY 2531	
40 ST AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5105 WILLISTON STREET			
6. SEX FEMALE	7. RACE WHITE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 07 27 97	10. AGE (In years lost birthday) 71	11. If Under 1 Tr. Months: 12. If Under 24 Hrs. Days: 13. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. FATHER'S NAME JAMES CRAFT		13. MOTHER'S MAIDEN NAME Lillie McMuller		14. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) no		16. SOCIAL SECURITY NO. -		17. INFORMANT ST AGNES RECORDS-BALTO MD 21229	
18. 412-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac arrest. DUE TO, OR AS A CONSEQUENCE OF: coronary heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 28 19 69 to JULY 2 1969 that (X) (we) last saw the deceased alive on JULY 2 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Shams-Pirzadeh		23B. DATE SIGNED 07 02 69		23C. PHYSICIAN'S NAME (Type) A. SHAMS-PIRZADEH	
23D. ADDRESS ST AGNES HOSP. CATON & WILKENS AVE		23E. DATE 7/5/69		23F. NAME OF CEMETERY OR CREMATORY Western Cemetery	
23G. LOCATION Baltimore, Md.		23H. DATE REC'D BY HEALTH DEPT. JUL 7 1969		23I. NAME OF REGISTRAR J. E. Taylor, M.D.	
23J. FUNERAL DIRECTOR Witby's Funeral Home		23K. ADDRESS 4101 Edmonson Ave		23L. DATE REC'D BY HEALTH DEPT. JUL 7 1969	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

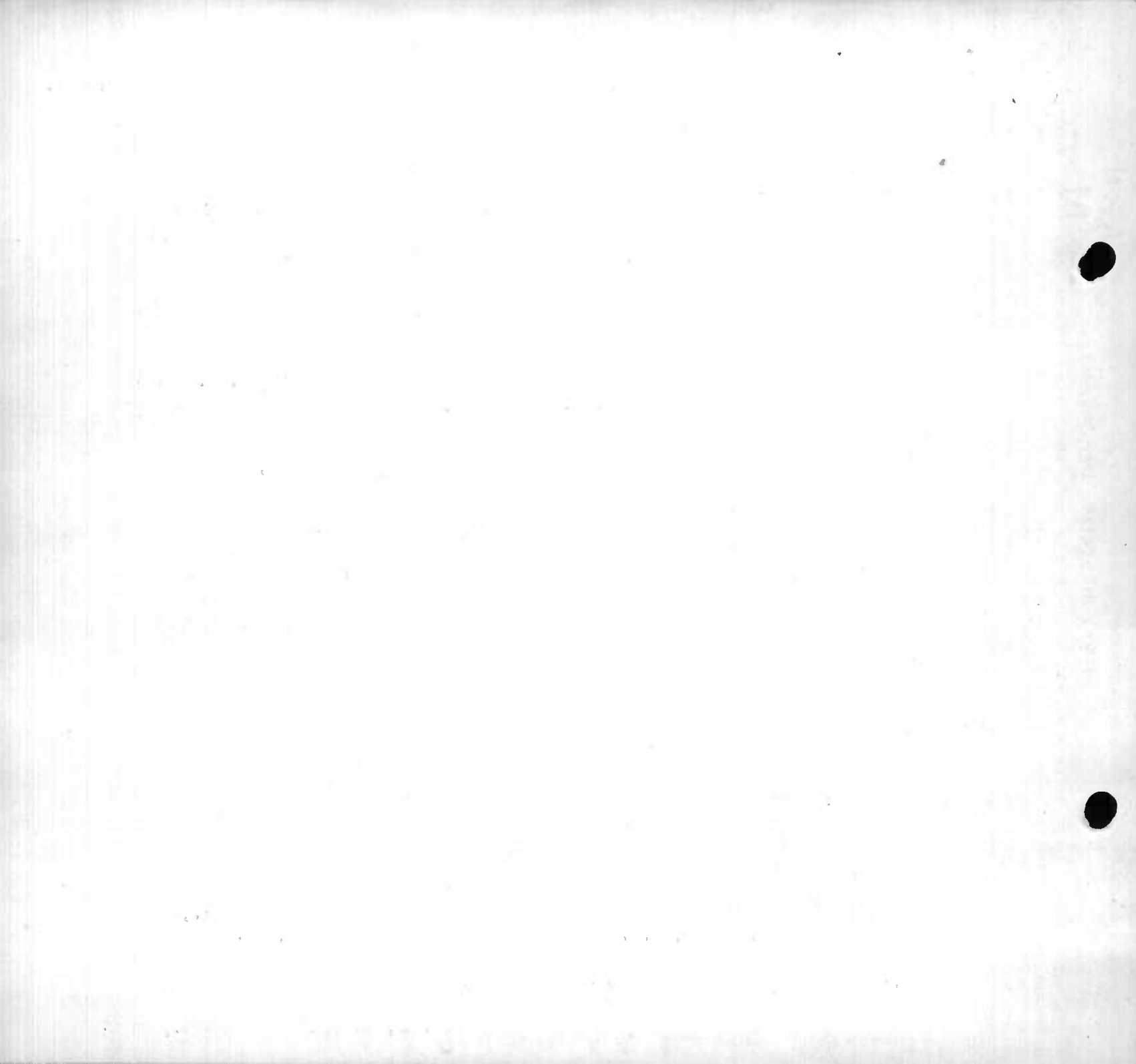
BALTIMORE CITY HEALTH DEPARTMENT			
69 6748		CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO. 69 6748	
1. NAME OF DECEASED (Type or Print) Anna Pysz		2. DATE AND HOUR OF DEATH 7-5-69 8:20 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland 21229		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Howard Co. C. CITY OR TOWN Jessup D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Washington Blvd. Box 239 #20794	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6- - 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Kareran		14. MOTHER'S MAIDEN NAME U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Nicholas Sasiadek		ADDRESS Box 239 Washington Blvd Jessup Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Strangled Umbilical Hernia -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Congestive Heart Failure - Myocardial Ischemia -			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Quirk		23B. DATE SIGNED July 5 '69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5 '69	
24C. NAME OF CEMETERY or CREMATORY Holy Rood		24D. LOCATION (City, town, or county) (State) Westbury L.I. New York	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR R. E. J. J. M. D.	
25C. FUNERAL DIRECTOR Howard County		ADDRESS Funeral Home of Harry Witzke	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6749	
69 6749 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JENNIE Kohn		2. DATE AND HOUR OF DEATH July 2, 1969 5:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 4501 Manordene Road			A. STATE MD. B. COUNTY 2864		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4501 Manordene Rd		
5. SEX 4	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/1885	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Frank Purdy		14. MOTHER'S MAIDEN NAME Ann		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-7358		17. INFORMANT Berkeley Hts, N. J. 07922 Mrs. Helen Williams, 17 Eaton Court	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion, acute			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardio-vascular Disease			unknown		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Never 19__ to __ 19__, that (I) (we) lost saw the deceased alive on never 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  Leo J. Gaver, M.D.				23B. DATE SIGNED 7/2/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 1 Mallow Hill Ave., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6750				BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 6750	
1. NAME OF DECEASED (Type or Print) Jas. Milton Bell				2. DATE AND HOUR OF DEATH July 4th 1969 9:00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) M.D. Howard Co. 6300					
5. SEX MALE				6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
8. DATE OF BIRTH 08-12-01				9. AGE (In years last birthday) 67		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY Canning Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME HARRY I. BELL				14. MOTHER'S MAIDEN NAME ALICE LANGRALL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217 01 5312		17. INFORMANT Mrs Miriam Bell ADDRESS 225 Chatham Rd. Ellicott City			
18. 441.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH DISSECTING ANEURISM.				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 HOURS			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) HYPERTENSIVE CARDIOVASCULAR DISEASE 20 years			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)					
21A. DATE OF OPERATION 0				21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) NO.		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 4th 1969 to July 4th 1969				that (I) (we) last saw the deceased alive on July 4th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cesar A. Bravo M.D.				23B. DATE SIGNED 7/4/69					
23C. PHYSICIAN'S NAME (Type) CESAR A. BRAVO M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE July 7 '69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969				25B. NAME OF REGISTRAR Robert E. Vabey M.D.		25C. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke ADDRESS Ellicott City Maryland			

Social Security Card issued 12-30-1936
to Jas. Milton Bell #217-01-5312
M.H. 3-25-71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6751	
BIRTH NO. 69 6751		1. NAME OF DECEASED (Type or Print) JOHN W GOODRICH		2. DATE AND HOUR OF DEATH 7-4-69 12.15 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 91 JENKINS MEMORIAL HOSPITAL			A. STATE MD B. COUNTY Balto. Co.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 5613 Edmonson Ave		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-92	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Guard			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md
13. FATHER'S NAME Lewis E Goodrich			14. MOTHER'S MAIDEN NAME Julia Kirby		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes unknown			16. SOCIAL SECURITY NO. 553-07-9362		17. INFORMANT Medical Records
18. 403 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremia (B) Nephrosclerosis and DUE TO, OR AS A CONSEQUENCE OF: (C) chronic pyelonephritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			ASCVD		
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-17-69 19 to 7-4 19 69 , that (I) (we) last saw the deceased alive on 7-4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. 12.15 PM					
23A. SIGNATURE J. Raymond Gladue				23B. DATE SIGNED 7-4-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/8/69		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NAT'L COM	
24D. LOCATION (City, town, or county) Balto Md		24E. LOCATION (State) Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Thomas J. Kerney Inc	
				ADDRESS Balto Md	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

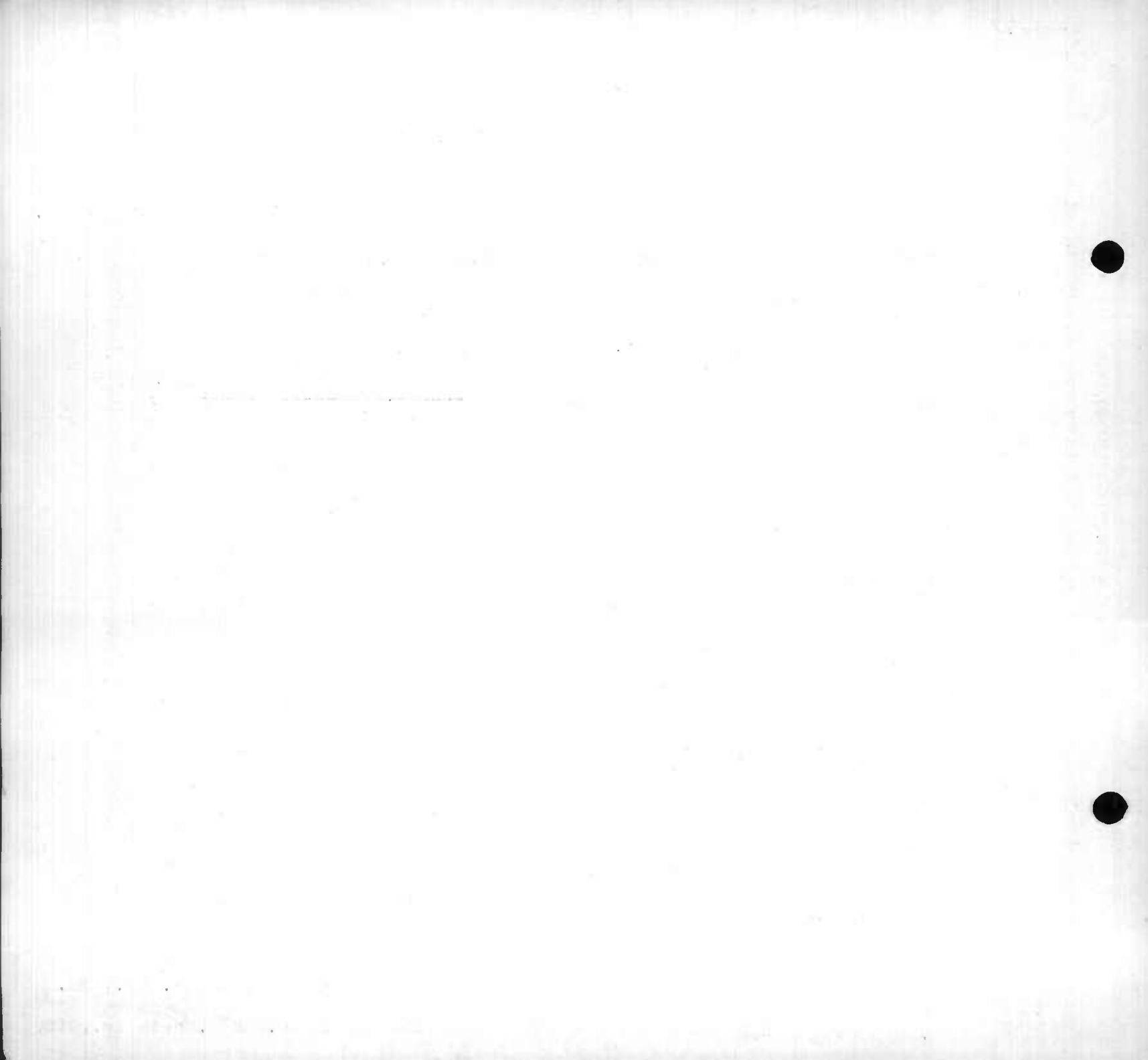
Baltimore City Health Department				REG. NO. <u>69 6752</u>
<div style="display: flex; justify-content: space-between;"> 69 6752 HINTZ MRS. LORETTA CERTIFICATE OF DEATH </div>				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HINTZ MRS. LORETTA, V.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>7-4-1969 at 5.05 am</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON-SECOURS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Baltimore St. BALTIMORE.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>719 S Dean St.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1883</u>	9. AGE (In years lost birth day) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>Baltimore</u>
13. FATHER'S NAME <u>N. Colas White</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs Edna Shipley</u> ADDRESS <u>719 S. Dean Street</u>	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. <u>1969</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>Fibrosarcoma of chest wall with metastases to lungs, adrenals, liver + myocardium</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="width: 10%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u></p> </div> </div>				
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Gastric ulcer</u></p>				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Permitted Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6.15.69</u> 19 to <u>7.4.1969</u> 19, that (I) (we) last saw the deceased alive on <u>7.3.69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Bilal Ahmed Qureshi</u>		23B. DATE SIGNED <u>July 4th 1969</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Dr. BILAL AHMED QURESHI</u>		23D. ADDRESS <u>BON-SECOURS Hospital Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-8-1969</u>	24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland 21224</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Talbot, M.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</u>		

Printed.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

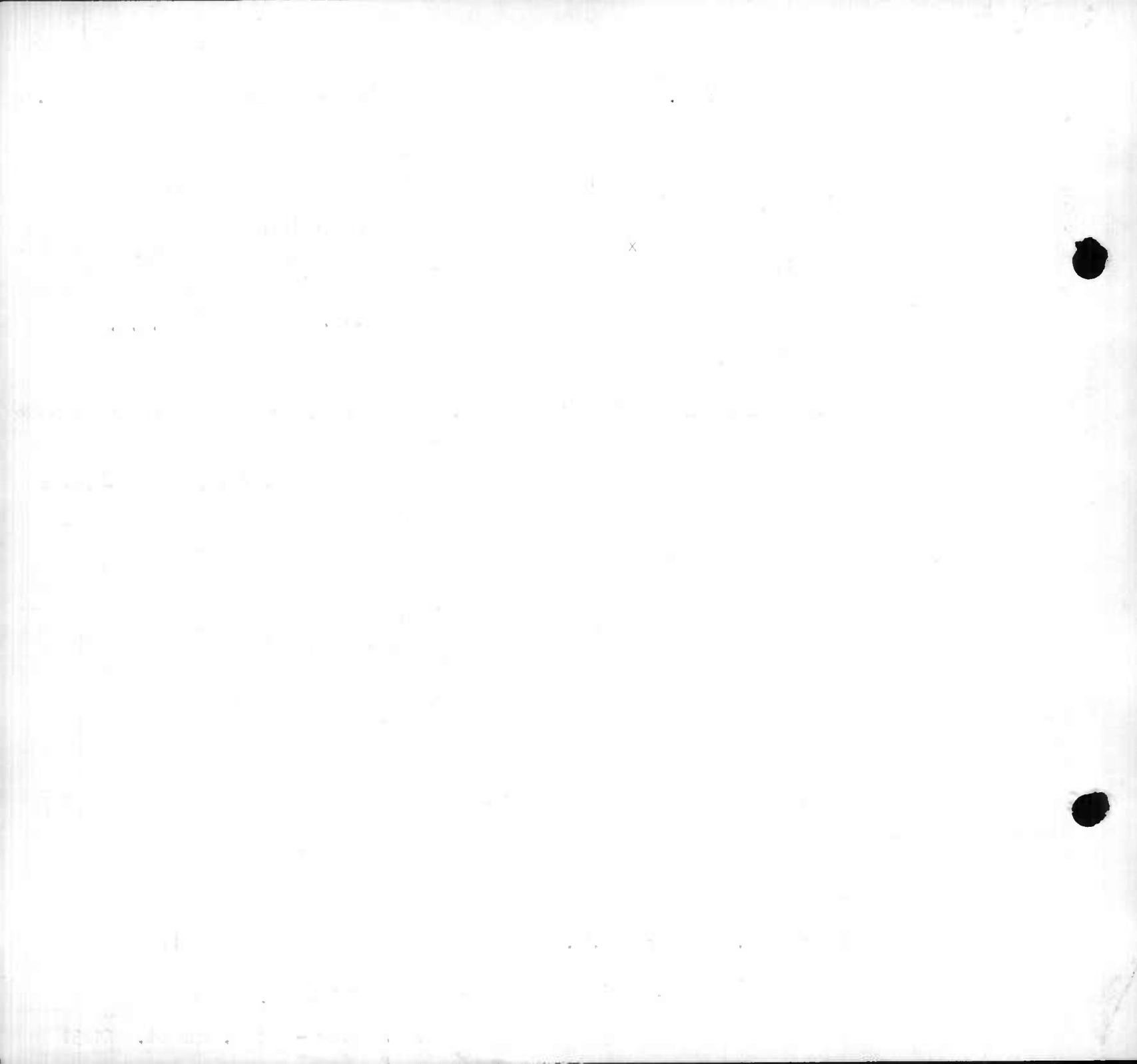
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 6753
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		AMELIA FISKE, FLORENCE SHAW (Mrs)		2. DATE AND HOUR OF DEATH July 3, 1969 1 5:30 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 91 KESWICK		A. STATE XXXXXXXXXX - MARYLAND 1201		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY		
		C. CITY OR TOWN BALTIMORE		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER XXXXXXXXXXXXXXXXXXXXX 3811 Canterbury Rd		
		Ambassador Apts.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 10, 1877	9. AGE (In years last birthday) 92 YRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN GEORGE SHAW		
14. MOTHER'S NAME ROSINA AMELIA WARDNER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. J 220-44-2804		17. INFORMANT RECORDS: KESWICK and Family Helen E. Shaw, H.H. - Keswick		
18. 404 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Intoxic Cardiovascular renal disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>March 1967</u> to <u>3 July 1969</u> , that (I) (we) last saw the deceased alive on <u>3 July 1969</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Harold P. Brecht		23B. DATE SIGNED 3 July 69		23C. PHYSICIAN'S NAME (Type) DEGREE
23D. ADDRESS DEGREE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/5/69	24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.
25A. DATE REC'D BY HEALTH DEPT. JULY 1969		25B. NAME OF REGISTRAR Wm. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av., Cityl



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. No. <u>69 6754</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>69 6754</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>Edward ANTHONY BAJERONAS</u>			2. DATE AND HOUR OF DEATH <u>7-5-69 3:45</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>201</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1913 BANK STREET</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-98</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoremen</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Stevedore</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>GEORGE Bajeronas</u>			14. MOTHER'S MAIDEN NAME <u>AGNES Lewandowski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-10-4880</u>		
17. INFORMANT <u>Mrs. Julia Bajeronas</u>			ADDRESS <u>1913 Bank Street #21231</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary embolism</u> (B) <u>Ischemic heart disease</u> (C) <u>Recurrent pleural effusion</u> <u>congestive heart failure</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>x 10 yrs.</u> <u>x 1 yr.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7-5-69</u> to <u>7-5-69</u> that (1) (we) last saw the deceased alive on <u>7-5-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stephen C. Achuff M.D.</u>				23B. DATE SIGNED <u>7/5/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>STEPHEN C. ACHUFF M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/9/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>			
25B. NAME OF REGISTRAR <u>George A. Weber, M.D.</u>		25C. FUNERAL DIRECTOR <u>George A. Weber - 705 S. Ann St. #21231</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>249-836</u>	
1. NAME OF DECEASED (Type or Print) <u>KATHLEEN MARY KOCYAN</u>			2. DATE AND HOUR OF DEATH <u>July 5, 1969</u> <u>6:10 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED <u>2X</u> <u>us Public Health Service Hospital</u> <u>Wyman Pk. Drive and 31st Street</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>F</u>			6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswp - Cashier</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		8. DATE OF BIRTH <u>April 15, 1929</u>
13. FATHER'S NAME <u>John Gibbons</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Mc Caffery</u>		9. AGE (In years lost birthday) <u>40</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>021 34 4755</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>
17. INFORMANT <u>John Kocyan - 7809 Jamesford Rd. #21222</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Squamous Cell Carcinoma of the Cervix</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>19A. DATE OF OPERATION 7/69, 9/68, 11/68, 12/68, 5/69</u> <u>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the Cervix</u> <u>20A. AUTOPSY? (Yes or No) NO</u> <u>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</u> <u>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</u> <u>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</u> <u>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</u> <u>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</u> <u>21E. INJURY OCCURRED</u> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>21F. HOW DID INJURY OCCUR?</u> <u>22. I certify that (this hospital) attended the deceased from July 4, 1969 to July 5, 1969 that (we) last saw the deceased alive on July 5, 1969 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.</u> <u>23A. SIGNATURE Bruce Lewis Gordon, M.D.</u> <u>23B. DATE SIGNED 5 July 1969</u> <u>23C. PHYSICIAN'S NAME (Type) Bruce L. Gordon M.D.</u> <u>23D. ADDRESS USPHS Hospital, Baltimore, Md.</u> <u>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</u> <u>24B. DATE 7/9/69</u> <u>24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery</u> <u>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</u> <u>25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969</u> <u>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</u> <u>25C. FUNERAL DIRECTOR ADDRESS GEORGE A. WEBER - 765 S. Ann St. #21231</u>

letter from U. S. P. H. S. Hospital
7. 23. 69 M. H.

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69 6756 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6756

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM ALLEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 1, 1969 1:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1817 Druid Hill Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year July 1, 1969 1:30 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1403	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8/3/95		10. AGE (In years last birthday) 74	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1817 Druid Hill Avenue
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Allen	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		14B. KIND OF BUSINESS OR INDUSTRY Retired		15. MOTHER'S MAIDEN NAME Alice	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW1		17. SOCIAL SECURITY NO. 217-01-3671		18. INFORMANT ADDRESS Hattie Winder 1817 Druid Hill Ave.	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/2/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.	

1 2 3 4 5 6 7 8 9

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 69 6757	
BIRTH NO. 69 6757				1. NAME OF DECEASED (Type or Print) <u>Rose Kennedy</u>		2. DATE AND HOUR OF DEATH <u>6/25/69</u> <u>8 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Anne Arundel</u>		5. CITY OR TOWN <u>Severn</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u>				E. STREET AND NUMBER <u>Box 313 Elmhurst Rd</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1912</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Connie Adams</u> ADDRESS <u>803 Fremont</u>		
18. <u>43101</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>BRAIN STEEL Compression</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Intracerebral Hemm</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>2 days</u>				(C) <u>Hypertension</u> <u>2 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>June 27</u> 19 <u>69</u> to <u>June 28</u> 19 <u>69</u> that (I) (<u>we</u>) last saw the deceased alive on <u>June 28</u> 19 <u>69</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Martin S. Schwartz</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/28/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Martin S. Schwartz</u> DEGREE				23D. ADDRESS <u>Univ Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7/3/69</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>66 W. Bond</u>			

69 6758 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

COTTMAN, CLARA

2. DATE AND HOUR OF DEATH

7/6/69

13:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

1604 Greenmount Avenue

21202

D. INSIDE CITY LIMITS?

YES ☒NO ☐

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-9-27

9. AGE (In years
lost birthday)

41

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Freeman Giles

14. MOTHER'S MAIDEN NAME

Sarah Cushman

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

21224

BCH: Records 4940 Eastern Ave. Balto. Mdd

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

HEPATIC COMA

12 HRS.

(B) DUE TO, OR AS A CONSEQUENCE OF:

LAENNEC'S CIRRHOSIS

3 YRS.

(C) DUE TO, OR AS A CONSEQUENCE OF:

CHRONIC ALCOHOLISM

NOT KNOWN

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

ANEMIA

3 YRS

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 6/20 19 69 to 7/6 19 69,
that ~~the~~ (we) last saw the deceased alive on 7/6 19 69 and that in (my) ~~own~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~did~~ (did not) view the body after death.

23A. SIGNATURE

Dennis W. Bleakley M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/6/69

23C. PHYSICIAN'S
NAME (Type)

Dennis W. Bleakley M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

7/10/69

Mt Auburn Cemetery

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1969

Robert E. Taylor, M.D.

Wm C March 928 E. North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
5-363

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELOISE ELOUISE C. STEWART		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1927 Guilford Ave. D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5 1969 4:40p M.		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1204	
6. SEX Female	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Aug 5, 1927		10. AGE (In years last birthday) 41	11. BIRTHPLACE (State or foreign country) Maryland		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Frank Jones		E. STREET AND NUMBER 1927 Guilford Ave.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mamie	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. Willie Stewart 1927 Guilford Ave	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Obesity APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> July 6, 1969					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/69		24C. NAME OF CEMETERY or CREMATORY Balto National Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969			
25B. NAME OF REGISTRAR Wm C March		25C. FUNERAL DIRECTOR ADDRESS 928 E. North Ave.			

19690006750

ENGINE

APR 6 1937

Harvard

Frank Jones

Radio

Mr. Willie Stewart 1837 Collier Ave

Partial 7/9/38 Radio National Com. Radio, Md.

Mr C M Ch 928 N. North Ave.

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B-416

69 6750

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6760

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret R. Blueford		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 424 Worsley Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1969 4:10 A.M.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 19, 1896		10. AGE (In years last birthday) 73 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Rachel Winder	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Bernard Hipkins 1240 Rossiter St.		ADDRESS	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69	
24C. NAME OF CEMETERY or CREMATORY Pleasant Rest Cemetery		24D. LOCATION (City, town, or county) (State) Towson, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

19690506751

78 1986, 10, 18

Alexander F. Kozlov

2000

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B-620

69 6761 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6761

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY BROOKS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 4 69 11:55a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4 69 11:55a M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1338		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-12-94		10. AGE (In years lost birthday) 74	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Joseph Brooks	
13. FATHER'S NAME Mary		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Mary		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 217-16-7707		18. INFORMANT Mrs. Julia Brooks 2206 Gordon Rd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		DATE SIGNED 7/5/69	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

IN

74

12-12-64

Joseph Brooks

Married

1917

214-16-7707 Mrs. Julia Brooks 2208 Gordon St.

Burial 7/6/62 St. Calvary Cemetery Anne Arundel City, Md.

Am 9 March 1962 E. North Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6762 CERTIFICATE OF DEATH

REG. NO. 69 6762

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Anna Frances Strozykowski

2. DATE AND HOUR OF DEATH

July 3 1969

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒No ☐

E. STREET AND NUMBER

1915 E. Pratt St.

5. SEX

F

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

June 12, 1895

9. AGE (In years
last birthday)

74

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

George Janowski

14. MOTHER'S MAIDEN NAME

Veronica (unknown)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216-18-3568

17. INFORMANT

Anna Jaworski

ADDRESS

1915 E. Pratt St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

Arteriosclerotic, Hypertensive

DUE TO, OR AS A CONSEQUENCE OF:

Cardiovascular Disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2/6/58

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Cerebral Thrombosis, Left Hemiplegia

Chronic Cystitis

9/17/64

9/24/64

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

No

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work

☐

Not While

At Work

☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 6 1958 to June 23 1969,
that (I) (we) last saw the deceased alive on June 23 1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph F. Drenga, M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

7/5/69

23C. PHYSICIAN'S
NAME (Type)

Joseph F. Drenga, M.D.

23D. ADDRESS

209 S. Chester Str.; Baltimore, Md. 21231

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

July 7

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION

(City, town, or county)

(State)

DUNDALK

M.D.

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1969

25B. NAME OF REGISTRAR

Robert E. Jansen, M.D.

25C. FUNERAL DIRECTOR

John M. Niles & Sons Inc.

ADDRESS

401 S. Chester St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6763
BIRTH NO. 69 6763		1. NAME OF DECEASED (Type or Print) HERBERT E. WILSON		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 7/2/69		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1304		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2207 Bryant Ave.		
5. SEX Male	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1911	9. AGE (In years last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Postal Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Herbert Wilson		14. MOTHER'S MAIDEN NAME Myrtle Koger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 216-01-7850		17. INFORMANT ADDRESS Catherine Wilson, 2207 Bryant Ave.
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 2 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7-1 19 68 to 7-2 19 69 that (I) (we) last saw the deceased alive on 6-1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE E. Hunter Wilson, Jr.		23B. DATE SIGNED 7-3-69		
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr. M.D.		23D. ADDRESS 803 Medical Arts Bldg. Balto, Mo.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/7/69	24C. NAME OF CEMETERY OR CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Gaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.



G-152

69 6764 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

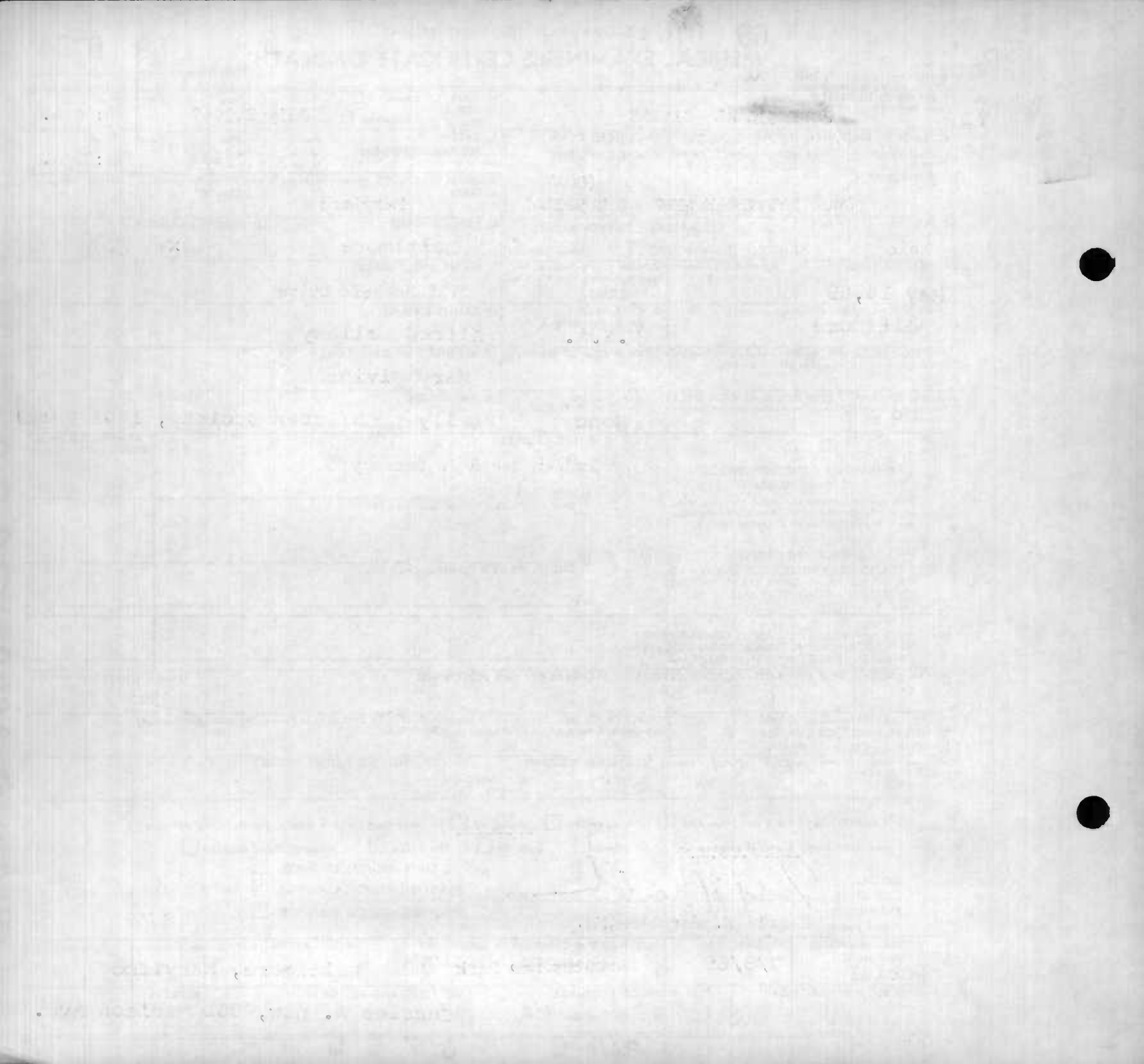
69 6764

BIRTH NO. 69-08517

REG. NO.

1. NAME OF DECEASED (Type or Print) DAVID CARL GIVINS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> July 2, 1969		Hour 8:00 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year July 2, 1969		Hour 8:00 A.	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 14, 69		10. AGE (In years last birthday) 6 weeks		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Alfred Bellany		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2562	
15. MOTHER'S MAIDEN NAME Mary Givins		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Family & Children Society, 1301 park		19. CAUSE OF DEATH Sudden death in infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Ronald N. Kornblum, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/2/69	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/69		24C. NAME OF CEMETERY or CREMATORY Parbutus Mem Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	
25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.					

19690306755



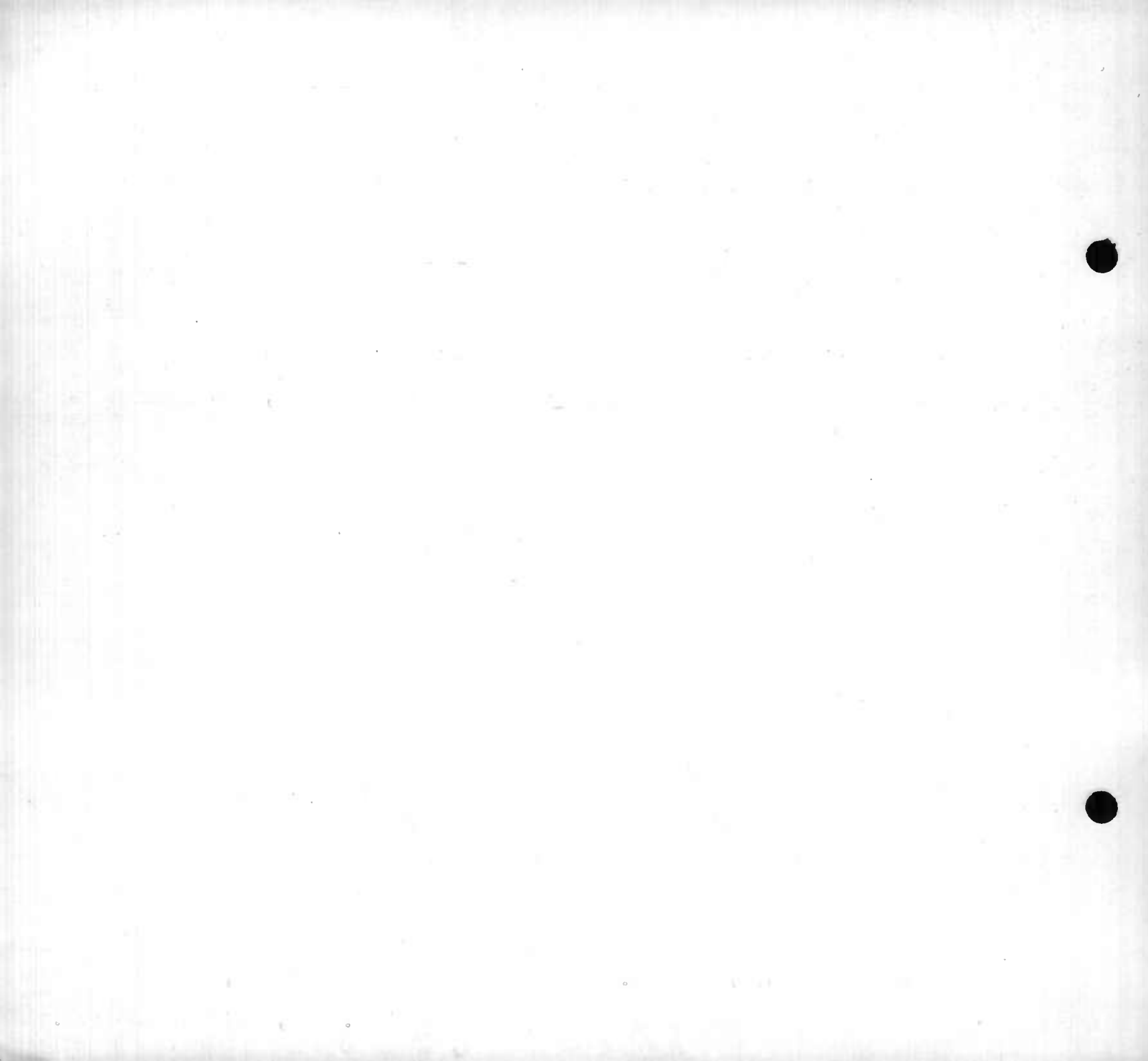
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6765 CERTIFICATE OF DEATH

REG. NO. 69 6765

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Edna Luttrell		6-30-69 3:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing Hill				A. STATE Maryland	
				B. COUNTY	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				C. CITY OR TOWN	
House wife				Baltimore	
10B. KIND OF BUSINESS OR INDUSTRY				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Fedrick Gaskins				Kathrine Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-14-4750		Edward Luttrell, 3104 Chelsea Terrace	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
174X-250.9		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			5 months
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			years
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/24 1969 to 6/30 1969, that (I) (we) lost saw the deceased alive on 6/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
ALAN H. MAEHT MD				7/1/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ALAN H. MAEHT MD				2 E Pearl St Baltimore, Md 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/3/69		Mt. Auburn	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 7 1969		Robert E. Fisher, MD		Charles R. Law, 802 Madison Ave.	



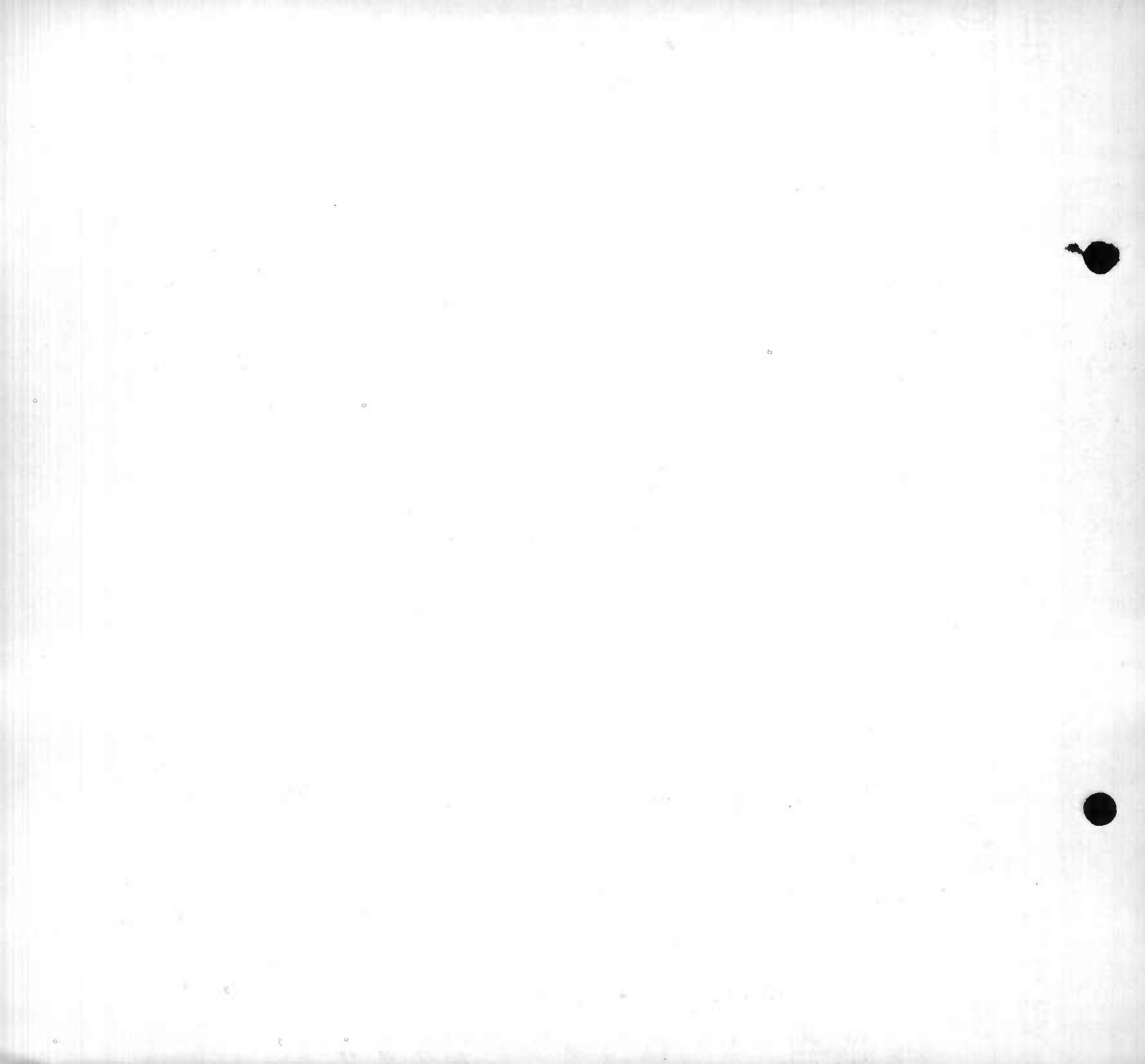
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6766 CERTIFICATE OF DEATH

REG. NO. 69 6766

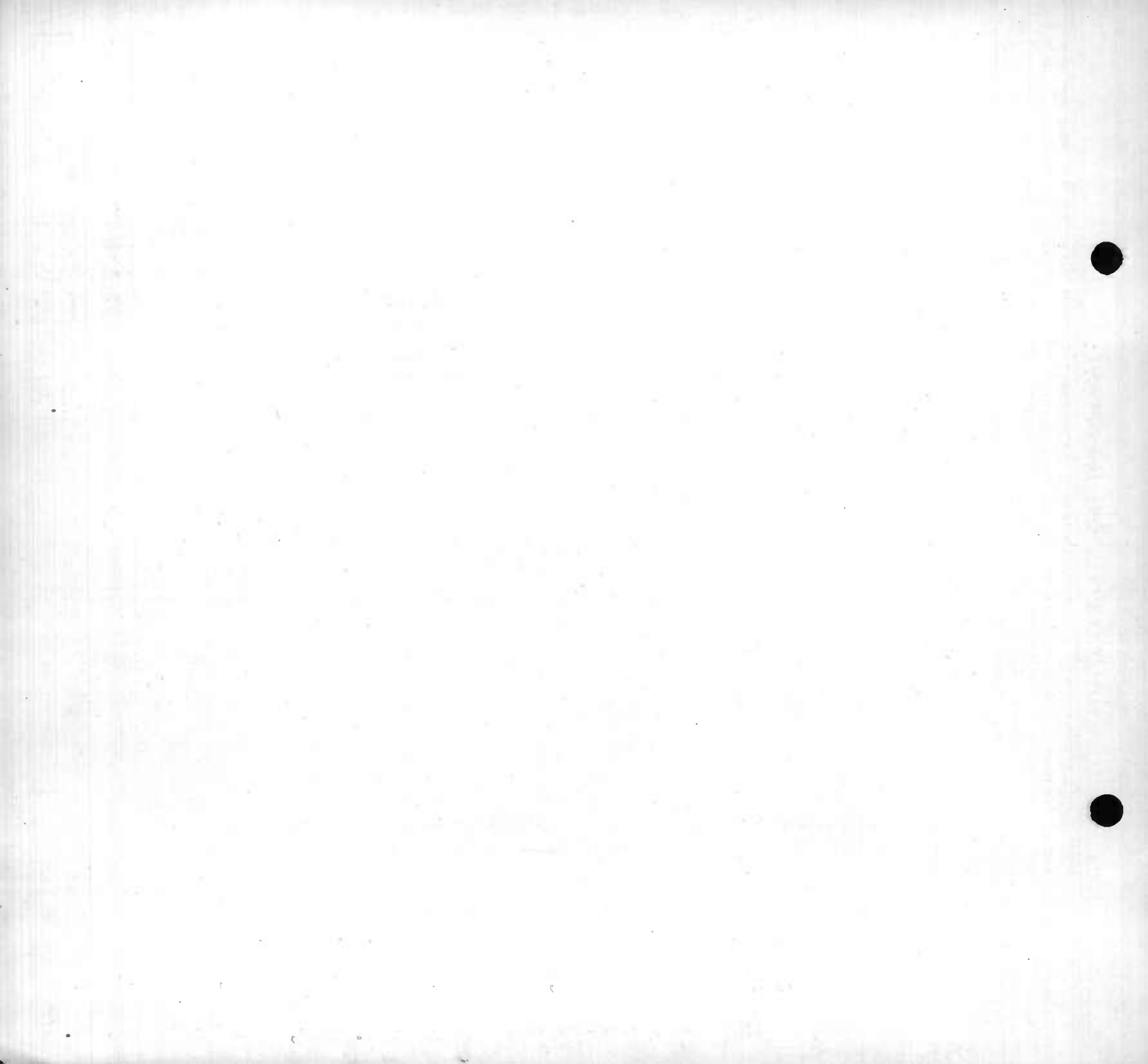
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ray, Florence</i>		2. DATE AND HOUR OF DEATH <i>6/28/69 4:30 P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>21217 1303</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hosp. of Md.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>N.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <i>10-7-90</i>		9. AGE (In years last birthday) <i>78</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William H. Fax</i>		14. MOTHER'S MAIDEN NAME <i>Myrtle Sousburry</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Bertha W. Cross, 1200 Whitelock St.</i>	
18. <i>41221</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute pul. edem.</i> (B) <i>ASHCVD.</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>6/14</i> 19 <i>69</i> to <i>6/28</i> 19 <i>69</i> . that (I) (we) last saw the deceased alive on <i>6/28</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Hyung K. Park M.D.</i>		23B. DATE SIGNED <i>6/28/69</i>		23C. PHYSICIAN'S NAME (Type) <i>Hyung K. Park M.D.</i>	
23D. ADDRESS <i>730 Ashburton St. Balto. Md 21218</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/1/69</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1969</i>	
25B. NAME OF REGISTRAR <i>Robert E. Jaben, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law, 802 Madison Ave.</i>		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6767	
BIRTH NO.		69 6767		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Maude G. Lee</i>		2. DATE AND HOUR OF DEATH <i>June 30, 1969 7:35 p.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1502</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>House-in-the-Pines (Belvedere)</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>N</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/28/96</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>72</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Edward Gates</i>		14. MOTHER'S MAIDEN NAME <i>Maude Withers</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-20-8247</i>		17. INFORMANT <i>Husband</i>	
18. <i>43391</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Thrombosis 4 days</i> (B) <i>Arteriosclerotic Vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>unknown</i> (C) <i>none</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>none</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/29 1969</i> to <i>6/30 1969</i> , that (I) (we) last saw the deceased alive on <i>6/30 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D. W. Stewart</i>		23B. DATE SIGNED <i>6/30/69</i>		23C. PHYSICIAN'S NAME (Type) <i>D. W. STEWART, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/3/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore, National</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1969</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law, 802 Madison Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. T-460		69 6768		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 6768	
1. NAME OF DECEASED (Type or Print) Taylor, James Joseph				2. DATE AND HOUR OF DEATH 7/5/69 12:45 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7011 Dunman Way 21222					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1897	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired ELECTRICIAN		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired ELECTRICIAN			10B. KIND OF BUSINESS OR INDUSTRY SHIP BLDG.			11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -UNK-				14. MOTHER'S MAIDEN NAME -UNK-				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 120 -UNK-	
16. SOCIAL SECURITY NO. 121-01-9917				17. INFORMANT Records: BCH 4940 Eastern Avenue 21224					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 436.91 Cardiac Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7min.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Cerebrovascular Accident 11 days (C) Acute Tubercular Process 10 days									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 6/26 19 69 to 7/5 19 69, that (1) (we) lost saw the deceased alive on 7/5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE John S. Cohen				23B. DATE SIGNED 7/5/69				23C. PHYSICIAN'S NAME (Type) John S. Cohen	
23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. Baltimore City Hospitals 21224				23E. FUNERAL DIRECTOR H. R. Ralley, Dundalk, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/5/1969		24C. NAME of CEMETERY or CREMATORY MT. OLIVET		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Joseph E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. R. Ralley, Dundalk, Md.					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year		Hour	
		JEROME HORNES		July 2, 1969								6:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE		3. DATE PRONOUNCED DEAD		Month		Day		Year		Hour	
34 Bon Secours Hospital		Maryland		July 2, 1969								6:55 P.M.	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH		10. AGE (In years last birthday)		If Under 1 Yr. If Under 24 Hrs.		E. STREET AND NUMBER							
3-23-47		22				900 N. Castle Street							
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME									
Balto. Md.		U.S.A.		FRAZIER HORNE									
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME									
Clothing Co.		Industry		LAURA McALL									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS							
No		214-4434		Adey Johnson		900 N. Castle Street							
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		(A) IMMEDIATE CAUSE		Gunshot wound of abdomen						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
E922.9				DUE TO, OR AS A CONSEQUENCE OF:									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:									
				(C) DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)									
2				Yes									
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?									
		office		'Mount Motor Co.' - 1635 Frederick Ave.									
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?									
7-2-69 4:30 P.				Apparently accidentally shot self while handling gun									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
Charles S. Springate, M.D.		Charles S. Springate, M.D.								July 3, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)							
Burial		7-7-69		Mt. Auburn		Andover Ave. Balto.							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS							
JUL 7 1969		Robert E. Jaber, M.D.		Calvin B. Scruggs		1412 E. Frederick St.							

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69 6770 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6770

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRISON JOHN FRANKLIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1969 11:07 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1969 11:07 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Bradshaw - Edgewood	
10. AGE (In years last birthday) 45		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3 July 23		E. STREET AND NUMBER 9118 Tremble Road	
11. BIRTHPLACE (State or foreign country) Del.		13. FATHER'S NAME JOHN T.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		15. MOTHER'S MAIDEN NAME LOUISE ENGLEHART	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes unk.		17. SOCIAL SECURITY NO. 322-24-1529	
18. INFORMANT Walter E. Franklin		ADDRESS Georgetown Del.	
19. CAUSE OF DEATH E814.1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Multiple Traumatic Injuries	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) June 29, 1969 10:10 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rte. 40 - Bradshaw	
		22F. HOW DID INJURY OCCUR? Pedestrian struck by car	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3 JUL 69	
24C. NAME OF CEMETERY or CREMATORY MILLSBORO		24D. LOCATION (City, town, or county) (State) MILLSBORO DELA.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Walter E. Franklin, M.D.	
		25C. FUNERAL DIRECTOR Dodd-Carey Inc. Eton.	

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JOHN T.

WASHINGTON

ROBERT E. HENNING

Washington Office & Justice Dept.

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WALTER

BRUCE L. STUBBS MILLBROOK

Washington Office

W-6130

69 6771 BALTIMORE CITY HEALTH DEPARTMENT

69 6771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) RAYMOND WARD		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year July 2, 1969		Hour 7:15 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year July 2, 1969		Hour 7:15 A.M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY Anne Arundel		
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Edgewater
9. DATE OF BIRTH Nov. 28, 1951		10. AGE (In years last birthday) 17	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF USA		13. FATHER'S NAME Oliver William Ward		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		15. MOTHER'S MAIDEN NAME Jessie L. Stickell		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 214-56-1889		18. INFORMANT Oliver W. Ward - same as # 5 above
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION 2-8-1961		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Rt. 124, 300' West of Rt. 424
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) June 28, 1969 2:46A m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto hit tree
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/2/69
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jul. 5, 1969	24C. NAME of CEMETERY or CREMATORY St. Mary's Cemetery	
24D. LOCATION (City, town, or county) (State) Annapolis A.A. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		
25B. NAME OF REGISTRAR James E. Farber, M.D.		25C. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.		

Paul M. Hall

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6772</u>
BIRTH NO. <u>W-436</u>		69 6772 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Blanche Waldorf</u>		2. DATE AND HOUR OF DEATH <u>6/30/69</u> <u>8:45 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL Hospital</u>		A. STATE <u>MD.</u> B. COUNTY <u>1202</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>3501 St. Paul St.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/88</u>	9. AGE (in years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. &</u>		13. FATHER'S NAME <u>William Waldorf</u>		
14. MOTHER'S MAIDEN NAME <u>Annandia</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Audrey Engel - 3300 Northbrook Rd</u>		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CHS injury? Cardiac Arrest?</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Septicemia?</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Identify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>69</u> to <u>6/30</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>6/30/69</u>		23C. PHYSICIAN'S NAME (Type) <u>CARLOS E. FOSSI, M.D.</u>
23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		23E. NAME OF REGISTRAR <u>James E. Taylor, M.D.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-2-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		
25B. NAME OF REGISTRAR <u>James E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		

ALLEN HENRIKSON, 10/15/84

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AMANDA HENRIKSON

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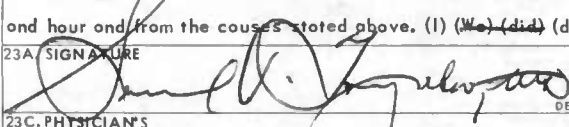
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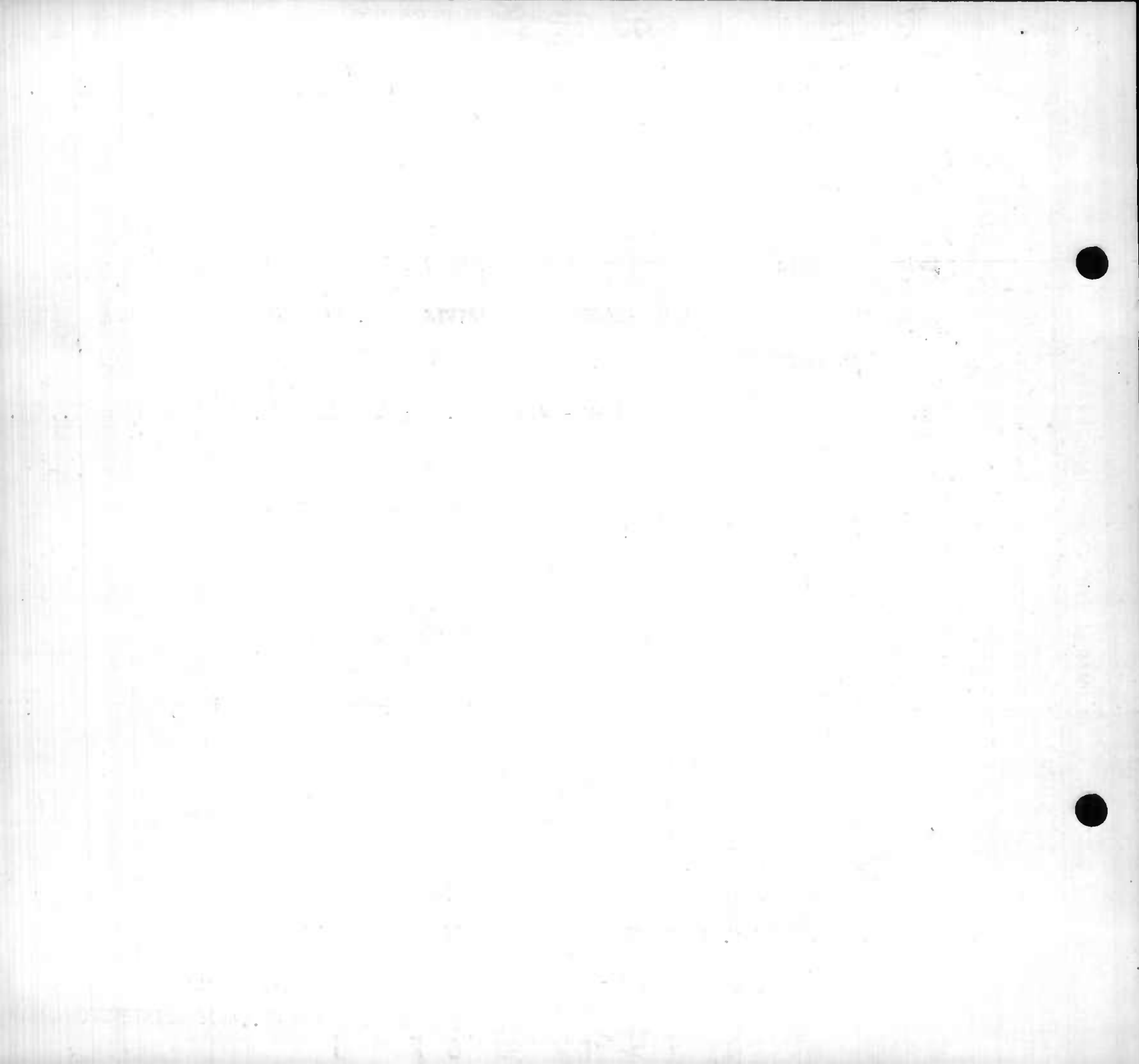
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6773	
B-425 69 6773				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) OSCAR BALLASOHN				2. DATE AND HOUR OF DEATH JULY 2, 1969 8 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PLEASANT MANOR NURSING HOME 90				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND <i>Balto.co.</i> B. COUNTY 5300 5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4502 DRESDEN ROAD	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 15, 1898	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY DRY CLEANER		11. BIRTHPLACE (State or foreign country) RIGA, LITHUANIA 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM BALLASOHN			14. MOTHER'S MAIDEN NAME ANNA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-32-1473A		17. INFORMANT MRS. BESSIE BALLASOHN, 5 COBBLESTONE CT., APT. 1 A	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 6/9 1953 to 7/2 1969 , that (I) (we) last saw the deceased alive on 6/27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 7/2/69	
23C. PHYSICIAN'S NAME (Type) SAMUEL V. TOMPAKOV				23D. ADDRESS 7211 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY TIFERETH ISRAEL ANSHE SFARD	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-430 69 6774				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6774	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Richard F. Plitt				2. DATE AND HOUR OF DEATH July 1st 1969 6 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY 2730	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 6316 GREENSPRING AVENUE, APT. 101 #21209			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/11	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMMERCIAL		10B. KIND OF BUSINESS OR INDUSTRY ARTIST		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR PLITT				14. MOTHER'S MAIDEN NAME EVELYN WOLF			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-0026		17. INFORMANT MRS. ZIPORAH PLITT, 6316 GREENSPRING AVE., APT. 101		ADDRESS	
18. 412.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST				CAUSE OF DEATH CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approx. 5 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		(B) DUE TO, OR AS A CONSEQUENCE OF: WITH CONGESTIVE FAILURE	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) (NO)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/27 1969 to 7/1 1969 , that (I) (we) last saw the deceased alive on 6/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE Joseph Deckerbaum, M.D.				23B. DATE SIGNED 7-1-69			
23C. PHYSICIAN'S NAME (Type) JOSEPH DECKERBAUM, M.D.				23D. ADDRESS 3502 WEST ROGERS AVE. BALTO. 21215 MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-69		24C. NAME OF CEMETERY or CREMATORY OHEB SHALOM MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Wm E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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16 G

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HAS

Cardiac Arrest

Hypertensive Atherosclerotic
Cardiovascular Disease
with congestive failure

NO

6/30 10/21 11/1

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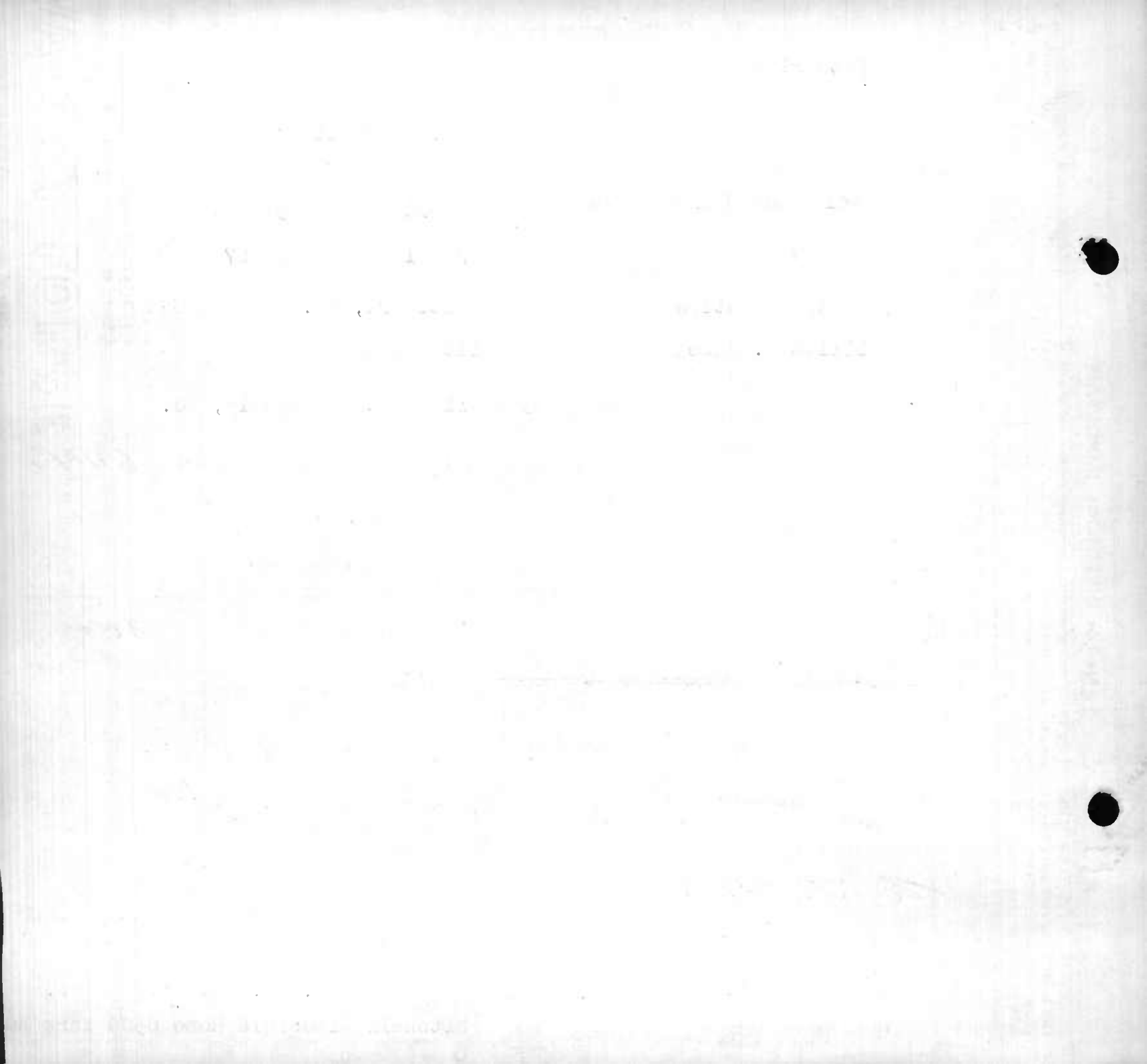
John Thompson, M.D.
John Thompson, M.D.

3005 West Rogers Ave.
7-1-63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

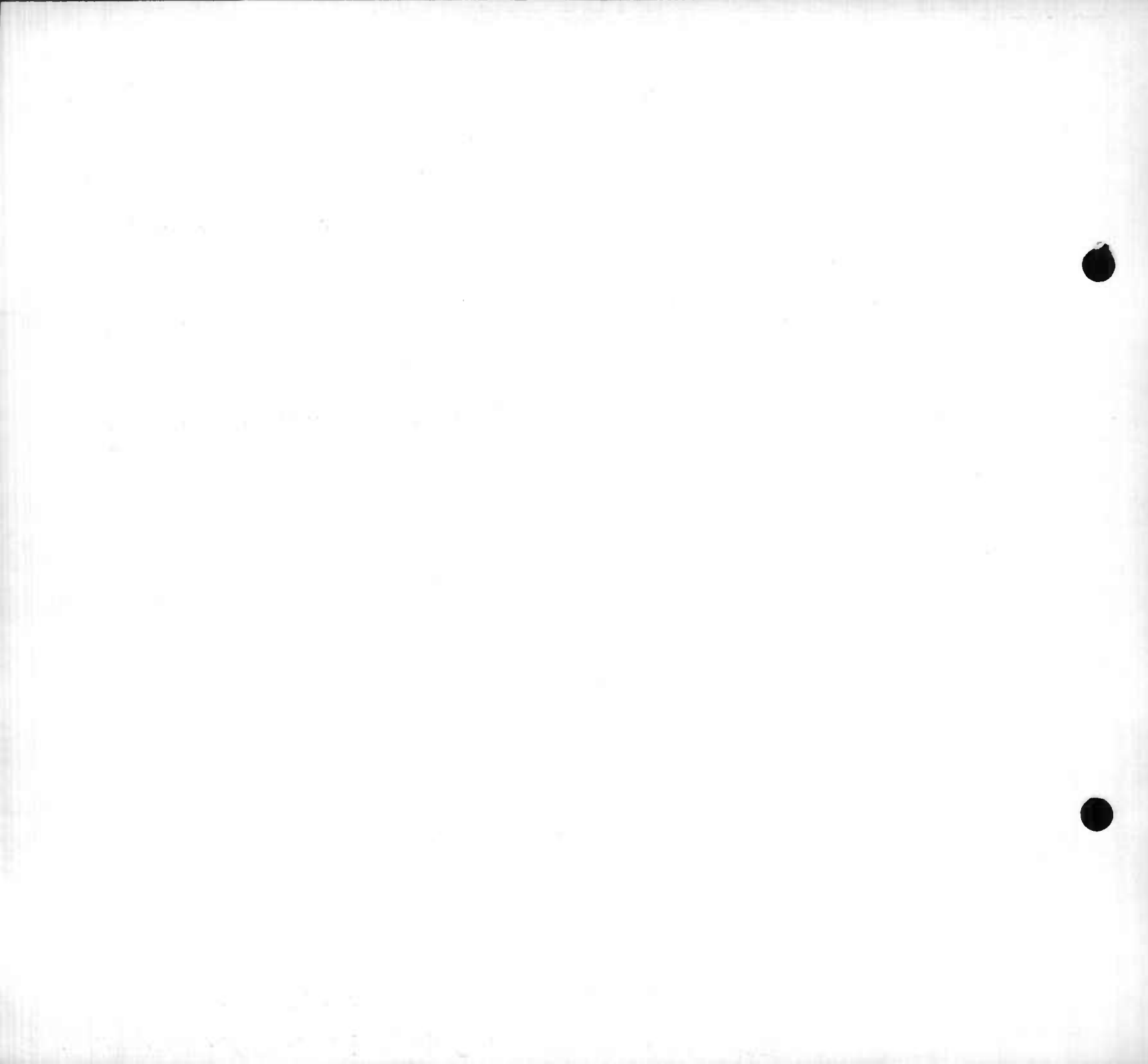
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6775
BIRTH NO. 69 6775		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Katharine E KATHERINE AIKEN		2. DATE AND HOUR OF DEATH 6/30/69 8:30 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mt. SINAI NURSING HOME 90 4613 Park Heights Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Phoenix D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Route 2 Box 52		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/30/1882	9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Aiken		
14. MOTHER'S MAIDEN NAME Alice Lemmon		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214 20 3582		17. INFORMANT ADDRESS Alice Thomas Phoenix, Md.		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA @ LUNG ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. URINARY INFECTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 2 m + s.				
19A. DATE OF OPERATION 6/29/69	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture @ Hip	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6/15/69 19 to 6/30 1969, that (I) (we) last saw the deceased alive on 6/29/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Morton M. Mower M.D.		23B. DATE SIGNED 6/30/69		23C. PHYSICIAN'S NAME (Type) MORTON M. MOWER M.D.
23D. ADDRESS 200 W. COLDSRING LA BALTO. MD.		24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7/3/69	24C. NAME OF CEMETERY or CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Fred. Rd. Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969	25B. NAME OF REGISTRAR James E. Fisher M.D.	25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6776		BALTIMORE CITY HEALTH DEPARTMENT		X		69 6776	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Elizabeth S. Mainster</u>				2. DATE AND HOUR OF DEATH <u>7/2-69</u> <u>9:30 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCEY HOSPITAL</u> <u>37</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>MD</u>		B. COUNTY <u>BALTO</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3716 Croydon Rd</u> <u>21207</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/16/07</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md</u>	
13. FATHER'S NAME <u>CHARLES L. Stokes</u>				14. MOTHER'S MAIDEN NAME <u>MARION SENSENEY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Raymond W. Mainster - Same</u>	
18. <u>183.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Adeno Carcinoma of Ovary Metastasis</u> <u>2) ASCITES</u> <u>3) DIFFUSE ASEVHD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>9/8/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>R-salpingo oophorectomy</u>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-2</u> <u>1969</u> to <u>7-2</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>7/2</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. MAKIPOUR</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>HOOSHANG - MAKIPOUR</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>7-5-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>	
24D. LOCATION <u>Frederick, Md</u>				24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>	
24G. DATE REC'D BY HEALTH DEPT.				24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <u>ARMAGOST Funeral Chapel - 400 Liberty Hgts.</u>	
24J. DATE REC'D BY HEALTH DEPT.				24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR	



S-140

69 6777 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6777

BIRTH NO.

REG. NO.

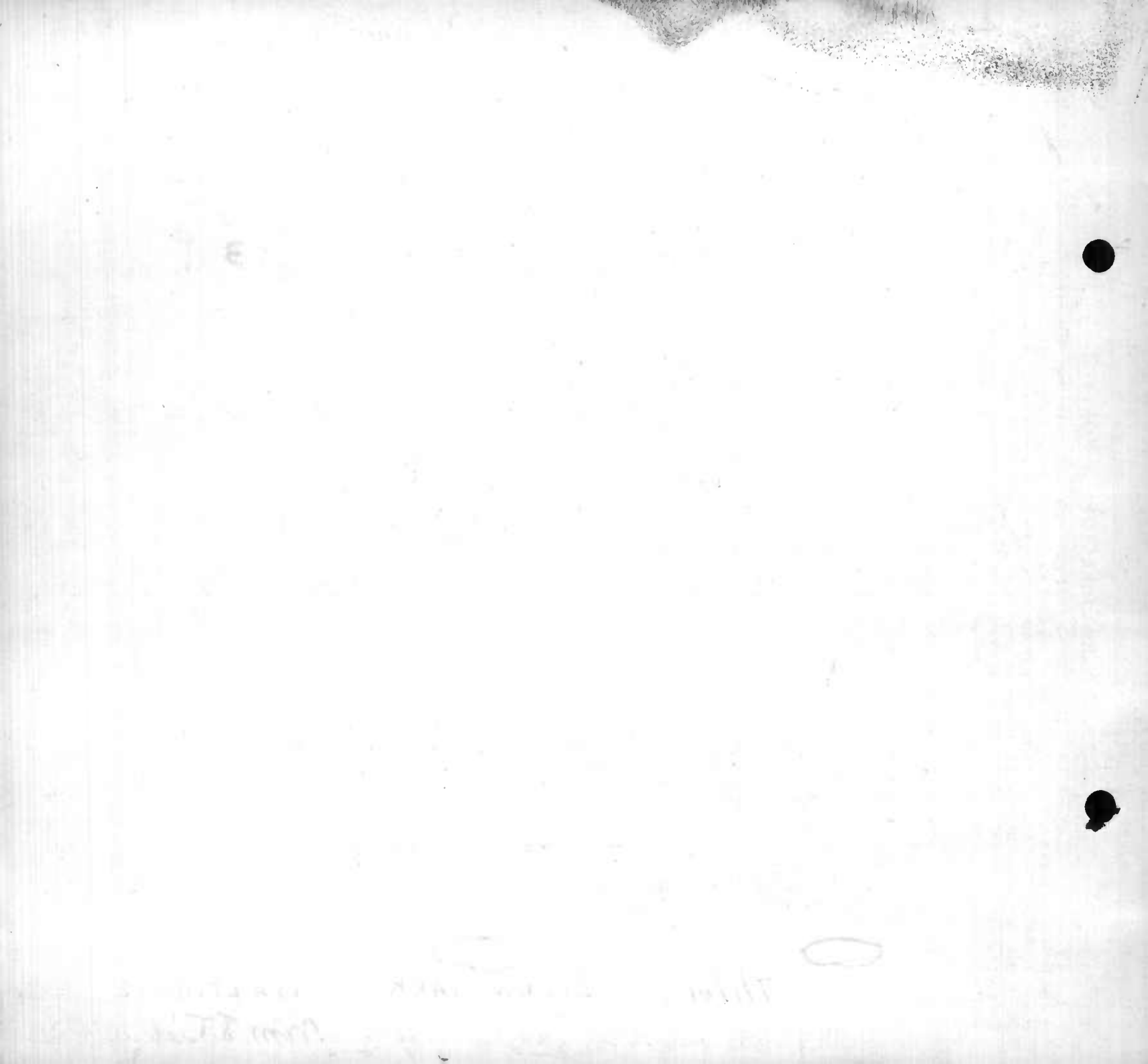
1. NAME OF DECEASED (Type or Print) ERMA J. SHIVELY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 2, 1969 Hour 8:50 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year July 2, 1969 Hour 8:50 A.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto		6. SEX Female 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH July 6, 1922 10. AGE (In years last birthday) 47 11. BIRTHPLACE (State or foreign country) Penna.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
12. CITIZEN OF U.S.A.		E. STREET AND NUMBER 3405 Rolling Road	
13. FATHER'S NAME Robert Ellenberger		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	
15. MOTHER'S MAIDEN NAME Myrtle Wheeler		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 213-14-4172		18. INFORMANT Boyd Shively ADDRESS 3405 Rolling Road	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/2/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 1969	
24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Long & Sons		ADDRESS 8728 Liberty Road, Randallstown, Md 21133	

11/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6778
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Della Williams</u>		2. DATE AND HOUR OF DEATH <u>6/29/69 7:30 pm</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>1101</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Melchor Nursing Home</u> <u>2327 North Charles st</u>		C. CITY OR TOWN <u>MARYLAND</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>8-9-1876</u>		9. AGE (In years lost birthday) <u>92</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Woodman Sample</u>		
14. MOTHER'S MAIDEN NAME <u>Violet Lloyd</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>214-54-5367</u>		17. INFORMANT <u>Theodore Williams</u> ADDRESS <u>1016 N Calvert st</u>		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anterosclerotic Cardiovascular disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION <u>0</u>		20. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (H) (this hospital) attended the deceased from <u>July 1968</u> to <u>June 1969</u> , that (H) (we) last saw the deceased alive on <u>June 18 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (H) (did) (did not) view the body after death.				
23A. SIGNATURE <u>O. Allan Sier, M.D.</u> <u>Relief Physician for O & M</u>		23B. DATE SIGNED <u>6/29/69</u>		23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS		24A. BURIAL (Cremation) REMOVAL (Specify)		
24B. DATE <u>7/1/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>LODEN PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE City</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm J. Tiekens & Sons</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH68 6779
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Dorothy May Lewis		2. DATE AND HOUR OF DEATH 7/1/69		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1903			
FULL NAME OF HOSPITAL OR INSTITUTION Mt. Siani Nursing Home 4613 Park Heights Avenue 90				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 308 S. Mount Street							
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/1907	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Leisher			14. MOTHER'S MAIDEN NAME Mary E. Davidson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. ???		17. INFORMANT Charles J. Lewis, 308 S. Mount St.		
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebrovascular Acc DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic CV Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Congestive Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 19 69 to 7/1 19 69 , that (I) (we) last saw the deceased alive on 7/1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. S. Kallins M.D.				23B. DATE SIGNED 7/2/69			
23C. PHYSICIAN'S NAME (Type) E. S. Kallins M. D.				23D. ADDRESS 6000 PARK HILL AV 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/4/69		24C. NAME OF CEMETERY or CREMATORY Ivy Hill Cemetery		24D. LOCATION (City, town, or county) (State) Laurel, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1969		25B. NAME OF REGISTRAR E. S. Kallins M.D.		25C. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6780

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Viola Hook

2. DATE AND HOUR OF DEATH

July 1, 1969

8:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Melchor Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

405 E. Fort Avenue

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3-3-1879

9. AGE (In years last birthday)

90

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Reany

14. MOTHER'S MAIDEN NAME

Dora A. Pead

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Agnes Lacer 1736 Webster St

18. 4123 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Anterior sclerotic Heart Dis. Generalized arterio-sclerosis

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 years

2

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/11 19 65 to 7/1 19 69, that (I) (we) last saw the deceased alive on 6/28 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harry Deibel M.D.

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

7/5/69

23C. PHYSICIAN'S NAME (Type)

HARRY DEIBEL M.D.

23D. ADDRESS

1226 Haver St Baltimore 71230

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7 5 69

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION

Brooklyn, A. A. Co. Md.

(City, town, or county) (State)

24E. ADDRESS

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1969

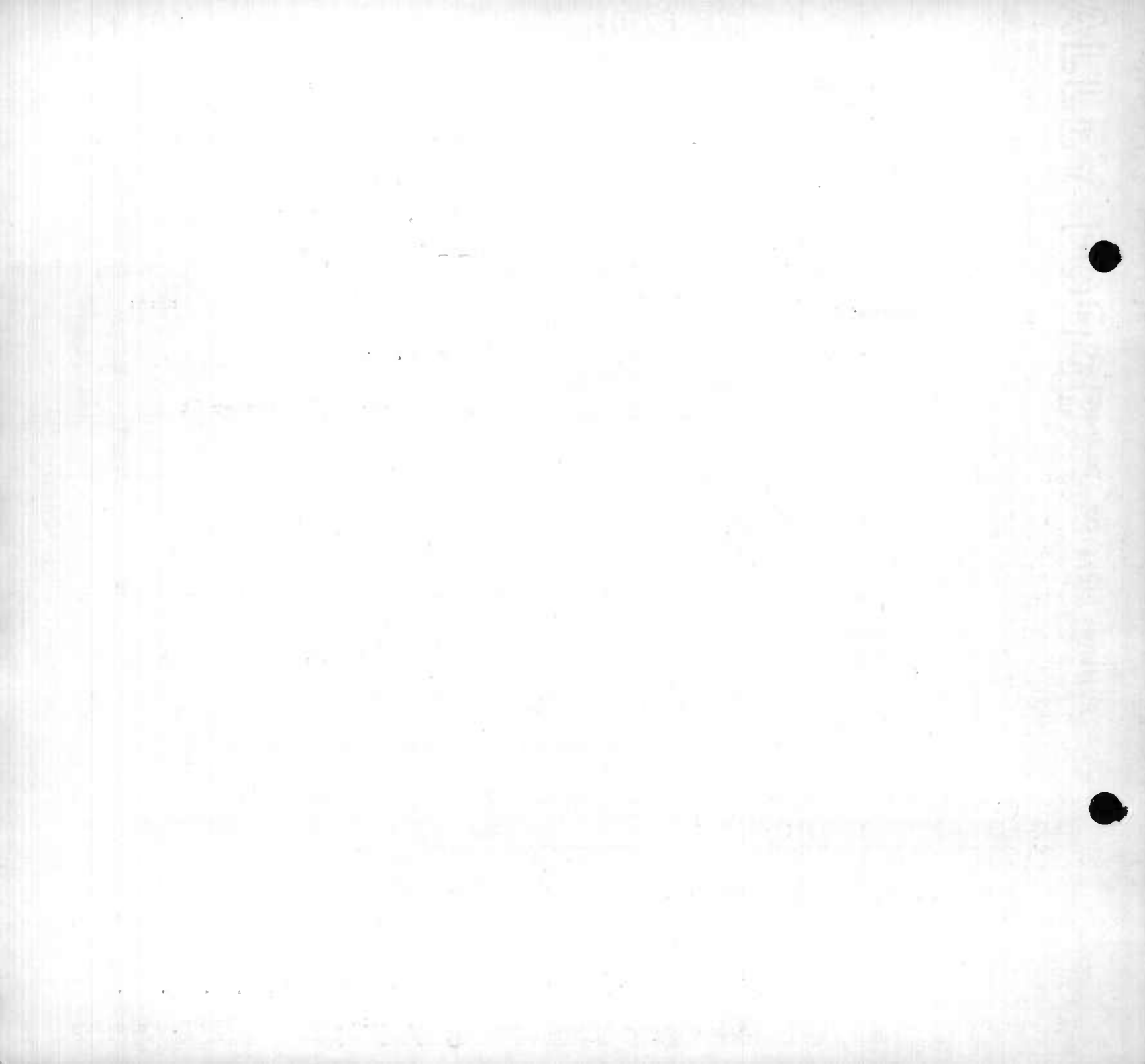
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Mc Gully

130 E. Fort Ave



FUNERAL DIRECTOR: IMPORTANT

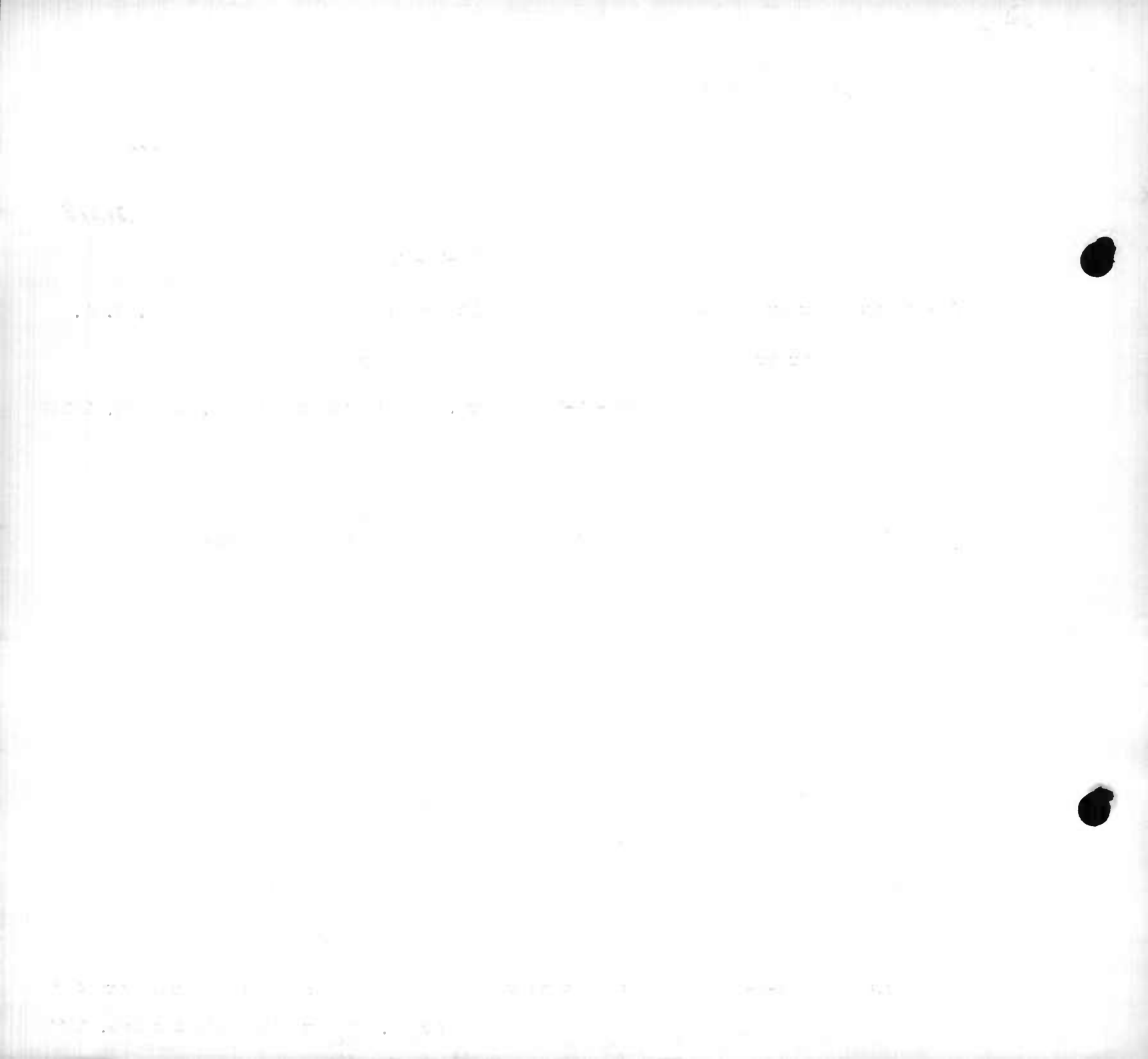
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-624 69 6781				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6781	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) GLORIA M. BERKLEY		2. DATE AND HOUR OF DEATH 7/4/69 1:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH 5-11-30 39		9. AGE (In years lost birthday) 39	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Housewife				10B. KIND OF BUSINESS OR INDUSTRY None at Home		11. BIRTHPLACE (State or foreign country) MAINE NEW HAMPSHIRE	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME BARRY BRUCE			
14. MOTHER'S MAIDEN NAME MARY ROBERTS				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>				17. INFORMANT Records: 4940 Eastern Ave. Baltimore, Maryland 21224			
18. 57101				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Gastrointestinal bleeding			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cirrhosis DUE TO, OR AS A CONSEQUENCE OF: unknown			
(C) Chronic Alcoholism DUE TO, OR AS A CONSEQUENCE OF: 15 years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) None				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) —			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) 6/25/69			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? —			
22. I certify that (1) this hospital attended the deceased from June 26 19 69 to July 4 19 69 , that (1) we last saw the deceased alive on July 4 19 69 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.							
23A. SIGNATURE Michael M. McConnell M.D.				23B. DATE SIGNED July 4, 1969			
23C. PHYSICIAN'S NAME (Type) Michael M. McConnell M.D.				23D. ADDRESS 4940 Eastern Ave. Balt., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/8/69			
24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.				24D. LOCATION (City, town, or county) (State) Edkridge Md.			
25A. DATE REC'D JUL 7 1969				25B. NAME OF REGISTRAR John E. Barber, R.D.			
25C. FUNERAL DIRECTOR John J. Gonzalez, Inc.				25D. ADDRESS 901 St. Helens St. Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6782	
69 6782 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Samuel N. Marker		2. DATE AND HOUR OF DEATH 7/2/69 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1204		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M			6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12-29-92
13. FATHER'S NAME John Marker			14. MOTHER'S MAIDEN NAME Amelia Erb		9. AGE (In years last birthday) 76 XXXXX
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 170-12-2394		11. BIRTHPLACE (State or foreign country) Pennsylvania
			17. INFORMANT Mrs. Sylvia Marker		12. CITIZEN OF WHAT COUNTRY? U. S. A.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE Branchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Lung TRAPPED under Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2/3/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Trapped Lung, Pneumonia		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/6 1969 to 7/2 1969 that (I) (we) last saw the deceased alive on 7/2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd B. Mandel M.D.				23B. DATE SIGNED 7/2/69	
23C. PHYSICIAN'S NAME (Type) Lloyd B. Mandel M.D.				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-69		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR James E. Farber, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard	
				ADDRESS 4107 Wilkens Ave. 21229	



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J-525

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

CERTIFICATE AMENDED - 7/15/69

1. NAME OF DECEASED (Type or Print) CHESTER B. JENSEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 517 Cathedral St. D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1969 1:30 p.m.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1102	
9. DATE OF BIRTH 8/27/1914		10. AGE (In years last birthday) 58	
11. BIRTHPLACE (State or foreign country) Brooklyn NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIGVARD JENSEN		14. MOTHER'S MAIDEN NAME KAIA OLSEN	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT MARINE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT WALTER JENSEN (Brother) 46 BARRY Lane DENT	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty alteration of the liver		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) Partial YES		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
25. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 7/15/69		26. HOW DID INJURY OCCUR? WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
28. ACTUAL SIGNATURE Werner U. Spitz, M.D.		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
30. DATE REC'D BY HEALTH DEPT. JUL 7 1969		31. NAME OF REGISTRAR James E. Taylor, M.D.	
32. DATE OF BURIAL OR CREMATION 7/15/69		33. NAME OF CEMETERY OR CREMATORY Louden Park Crem.	
34. LOCATION (City, town, or county) (State) Baltimore - Maryland		35. FUNERAL DIRECTOR Wm J. Tickner & Sons	

19690206774

7/10/69 - Letter from Office of the Chief Medical Examiner, Werner U. Spitz, M.D.
Deputy Chief Medical Examiner, dated July 8, 1969/ *WUS*

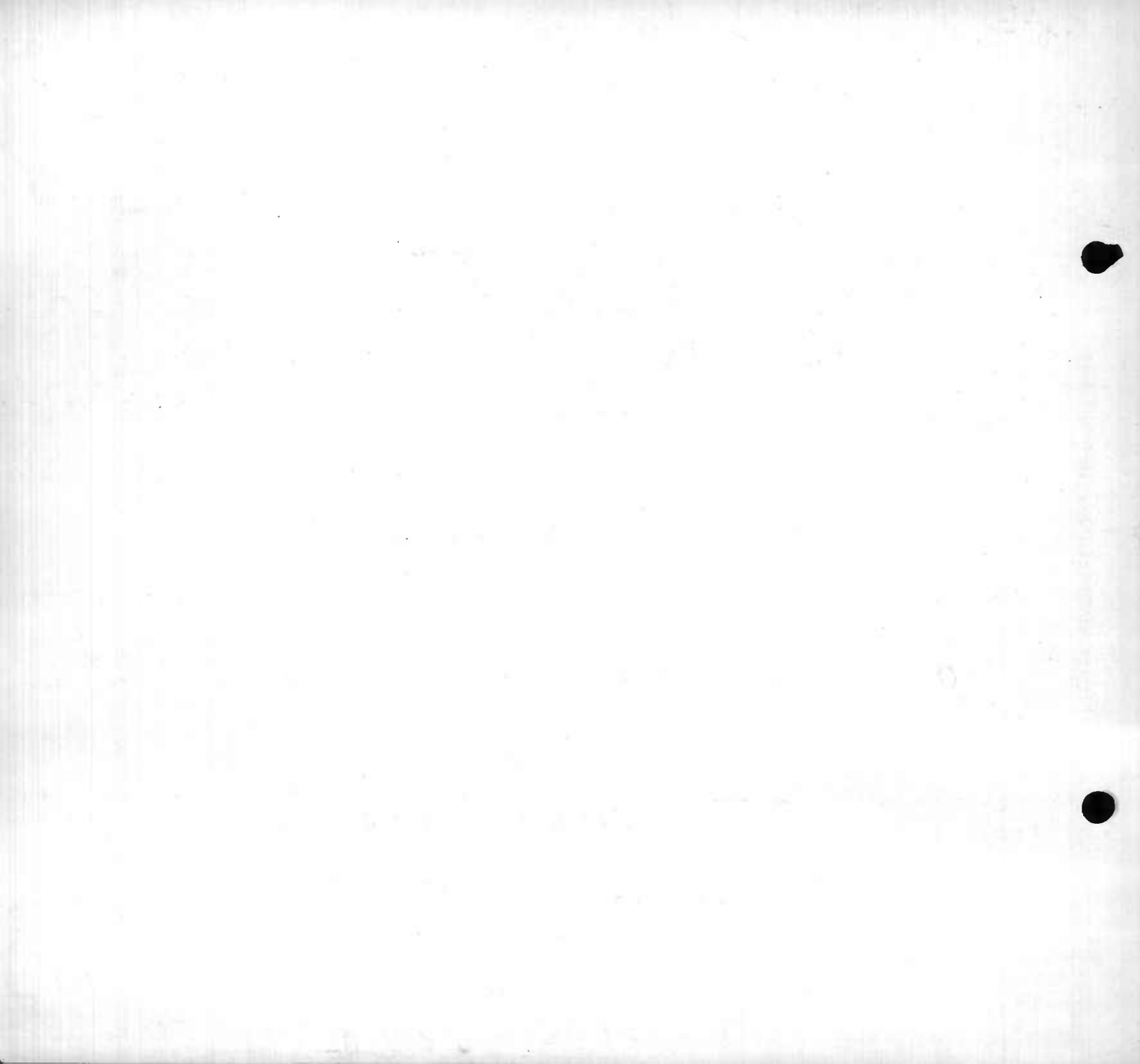
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6784	
BIRTH NO. 5		69 6784		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Clarence P. Bunting</u>		2. DATE AND HOUR OF DEATH <u>June 30, 1969</u> <u>8:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <u>Maryland</u> B. COUNTY <u>13 48</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Pleasant Manor N H</u> <u>4615 Park Heights Ave.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1208 W 41st Street</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Oct 1883</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bekmar Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Winfield Bunting</u>		14. MOTHER'S MAIDEN NAME <u>Molly Wooden</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 10 7251</u>		17. INFORMANT <u>Mrs Robt Shearer</u>	
18. <u>15-3131</u>		CAUSE OF DEATH		ADDRESS <u>3743 Beech Ave</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>C. LIVER</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>May 21, 1969</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>General Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>May 20-1969</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>C. Lower bowel</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>C. Liver + Lower bowel</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>10-1</u> 19 <u>69</u> to <u>June 30</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 30</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lawrence J Shimanek</u>				23B. DATE SIGNED <u>7-1-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lawrence J Shimanek</u>		23D. ADDRESS <u>3711 Falls Road</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3 July 69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		25B. NAME OF REGISTRAR <u>James E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>	
25D. ADDRESS <u>1111 N. ...</u>					



1
D-534

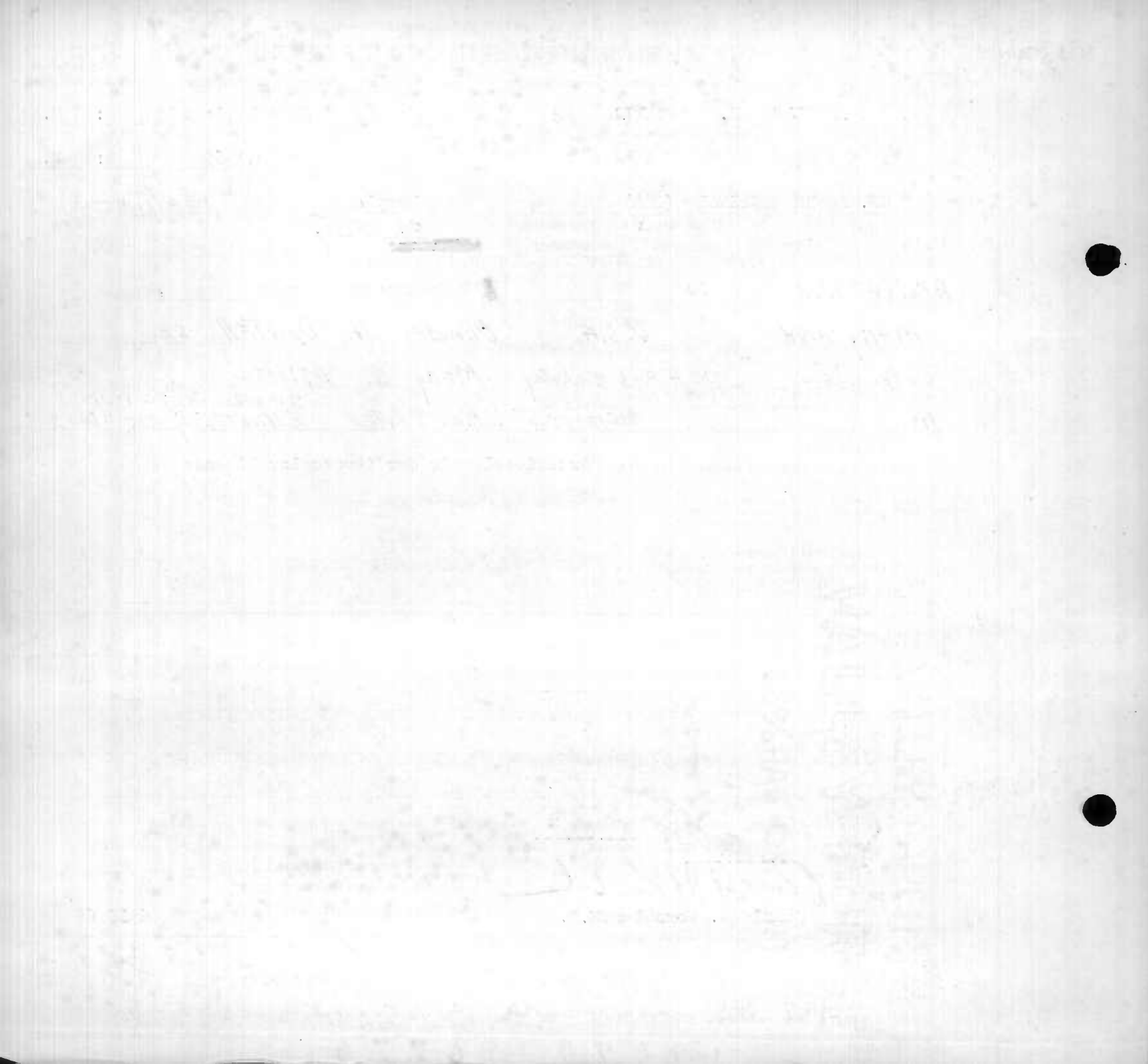
69 6785 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6785

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES H. DONTELL Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1969 8:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 29, 1969 8:40 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Ellicott City	
9. DATE OF BIRTH April 27 1910		10. AGE (In years lost birthday) 59	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		14B. KIND OF BUSINESS OR INDUSTRY DCA Food Industry	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-10-3565	
15. MOTHER'S MAIDEN NAME Mary C. Miller		18. INFORMANT Lillian DonteLL	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 7-3-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-69	
24C. NAME OF CEMETERY or CREMATORY Norland Cem.		24D. LOCATION (City, town, or county) (State) Chambersburg PA.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Walter E. Sauer, M.D.	
25C. FUNERAL DIRECTOR Agi Bottom Slack FUNERAL HOME		25D. ADDRESS Ellicott City, Md 21043	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6786	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE H. DAVIS		2. DATE AND HOUR OF DEATH 7/2/69 11:35 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2712		
FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW NURSING CENTER 1213 LIGHT STREET BALTO. MD-21230			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M			6. RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor (Retired)		10B. KIND OF BUSINESS OR INDUSTRY School		8. DATE OF BIRTH 3/26/1899	
13. FATHER'S NAME Geo. Davis		14. MOTHER'S MAIDEN NAME Unknown		9. AGE (In years last birthday) 70	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-16-3367		17. INFORMANT Nursing Home Record	
18. 433.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Branchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myeloid Cerebral Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Arteriosclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 5 19 69 to July 2 19 69 , that (I) (we) last saw the deceased alive on July 2 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. C. Alevisatos, M.D.				23B. DATE SIGNED July 3, 1969	
23C. PHYSICIAN'S NAME (Type) H. C. ALEVISATOS, M.D.		23D. ADDRESS 1207 5th and Street Baltimore, Md 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY or CREMATORY Arbutus mem. PK	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 7 1969		24F. NAME OF REGISTRAR James E. Garber, M.D.	
24G. DATE REC'D BY HEALTH DEPT. JUL 7 1969		24H. NAME OF REGISTRAR James E. Garber, M.D.		24I. FUNERAL DIRECTOR Wm. Chaturan, Jr.	
24J. ADDRESS 1701 McCallister St.		24K. ADDRESS Balto. Md.		24L. ADDRESS	

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1912 1912 1912 1912 1912 1912 1912 1912 1912 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6787		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6787	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Simmons Mr. Michael J. J.</i>		2. DATE AND HOUR OF DEATH <i>7.3.1969 9 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		5. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home and Hospital</i> <i>100 N Broadway Md.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <i>Male</i>		7. RACE <i>W</i>		8. DATE OF BIRTH <i>6/13/98</i>	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>71</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ret-Detective Lt.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. City</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John J. Simmons</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Joyce</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.America</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>219-28-4707</i>		17. INFORMANT <i>Mr. Simmons.</i> ADDRESS <i>Same as his</i>	
18. <i>162-1</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic Ca lungs liver multi</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) <i>CHF</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>week</i>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>6-25-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-25-69</i> 19 <i>69</i> to <i>7-3-69</i> 19 <i>69</i>		that (I) (we) last saw the deceased alive on <i>7-3-1969</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Corazon Z. Vergara, M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7-3-1969</i>	
23C. PHYSICIAN'S NAME (Type) <i>CORAZON Z. VERGARA, M.D.</i>		23D. ADDRESS <i>Church Home & Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/69</i>		24C. NAME of CEMETERY or CREMATORY <i>Sacred Heart of Jesus Cem. Baltimore, Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>7/7/69</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>		25D. ADDRESS <i>63331 Brooks Lane</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 6788

BIRTH NO. 67-16782

REG. NO.

1. NAME OF DECEASED
(Type or Print)

T.

TIFFANY DUBIEL

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3. DATE

Month

Day

Year

Hour

FILL IN IF DECEASED IN HOSPITAL OR INSTITUTION (Give address or location)
OR INSTITUTION

PRONOUNCED DEAD

July

1.

1969

4:14 a

M.

FILL IN IF DECEASED IN HOSPITAL OR INSTITUTION (Give address or location)

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Johns Hopkins Hospital D.O.A.

Maryland

702

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

White

WIDOWED ☐DIVORCED ☐

Balto.

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

8/24/67

2

2513 Ashland Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Baltimore, Md.

George Dubiel

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

none

none

Laurel Sponaugle

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT Balto. Md. 21222 ADDRESS

Karen Conrad, aunt, 33 Colony Hill Ct

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

Arsenic poisoning complicated by Pneumonia

(A) IMMEDIATE CAUSE

Food Poisoning

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

home

2513 Ashland Ave.

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

6

29

69

?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☒

Ingestion of arsenic from unknown source ingestion of contaminated food

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ ~~Accident~~ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner JULY 1, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7/5/69

Glen Haven Mem. Park

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1969

Robert E. Zaby, M.D.

Schimunek Funeral Home, Inc.

672601 E. Madison St.

Letter from M.E.'s office

7-15-70

M.H.

Should be coded to E980.7
N 985.1

changed too late - 1970
to change IBT card -
Tabulations for 1969 had been completed

VALLEY FORGE

CONFIDENTIAL

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

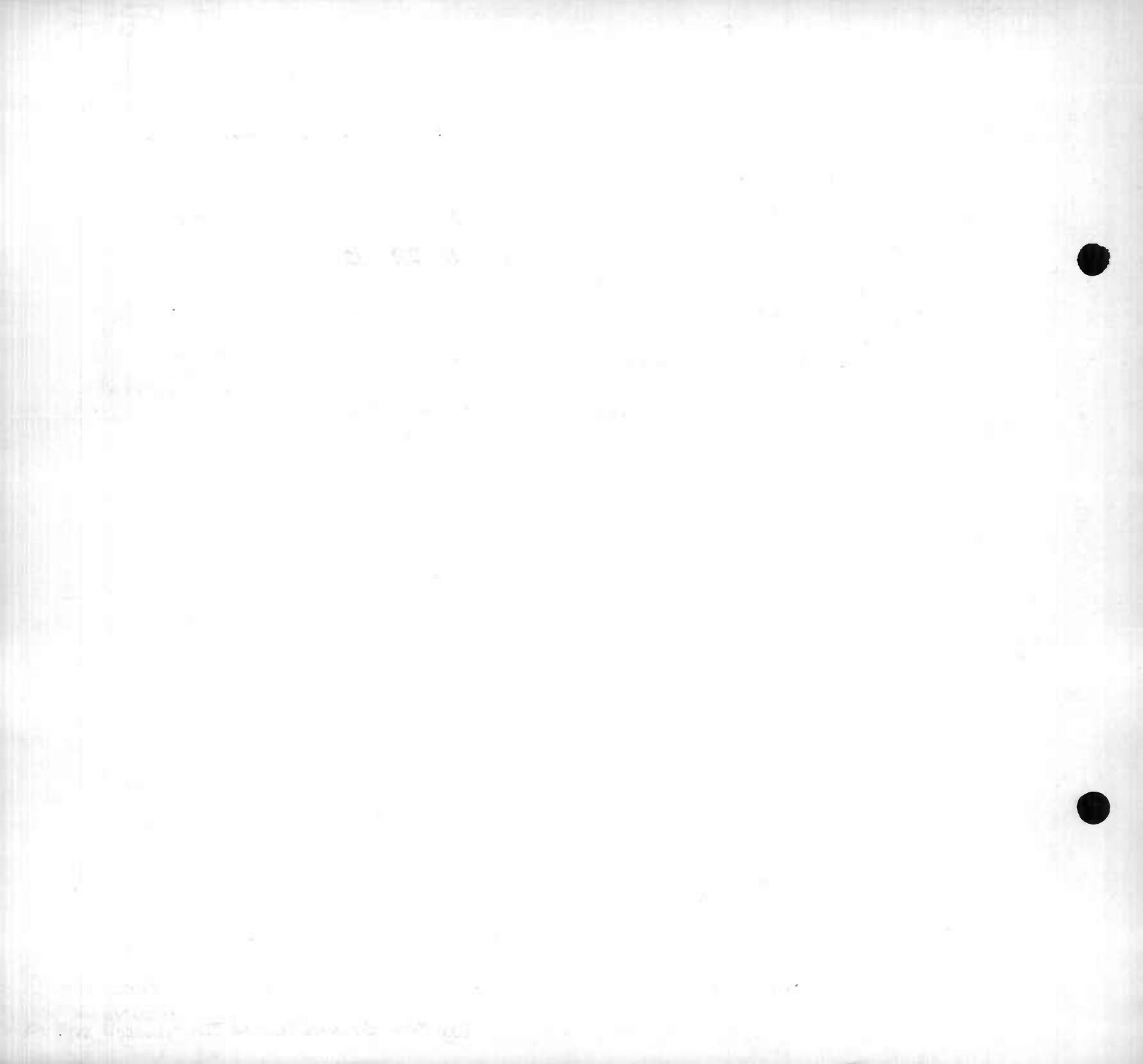
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6789</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>69 6789</u>					
1. NAME OF DECEASED (Type or Print) <u>FRANK ROBERT STAMM</u>			2. DATE AND HOUR OF DEATH <u>JUNE 30, 1969 6:10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>36 FRANKLIN SQUARE HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2102</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>SERGEANT 1258 SARGENT ST. 21223</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/03</u>	9. AGE (In years last birthday) <u>65</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Carpenter</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>FRANK ROBERT STAMM</u>			14. MOTHER'S MAIDEN NAME <u>HENRIETTA HEISNER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>213-08-2942</u>		
17. INFORMANT <u>FLORENCE STAMM</u>			ADDRESS <u>SERGEANT 1258 SARGENT ST.</u>		
18. CAUSE OF DEATH <u>155.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEPATOMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 17, 1969</u> to <u>JUNE 30, 1969</u> that (I) (we) last saw the deceased alive on <u>JUNE 30, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald H. Gecover, M.D.</u>			23B. DATE SIGNED <u>6-30-69</u>		
23C. PHYSICIAN'S NAME (Type) <u>RONALD H. GECOVER, M.D.</u>			23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jul 5, 1969</u>		24C. NAME of CEMETERY or CREMATORY <u>Oaklawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		25B. NAME OF REGISTRAR <u>James E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR <u>George H. Smith 814 W 36 St.</u>	
25D. ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6790	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 1. NAME OF DECEASED (Type or Print) HARRIS John 2. DATE AND HOUR OF DEATH 6/30/69 4:50 p.m. </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital Balto. Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY md C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1501 Gorsuch Ave 907		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-29-14	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME Thomas HARRIS			14. MOTHER'S MAIDEN NAME MARY HAMILTON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 183-04-9885		17. INFORMANT LAURA H. BARGER ADDRESS 100 GREEN MEADOW DR. LUTHERVILLE, MD. 21093	
18. 4-10-0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: 7 1/2 yrs. (C) Hypertensive & V.R.D. 9 yrs.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1960 to 30 June 1969 , that (I) (we) last saw the deceased alive on 30 June 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis E. Wice M.D.				23B. DATE SIGNED 6/30/69	
23C. PHYSICIAN'S NAME (Type) Louis E. WICE M.D.				23D. ADDRESS 920 ST. PAUL ST.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-69		24C. NAME of CEMETERY or CREMATORY MT. ROCK CEMETERY	
24D. LOCATION Lewistown		24E. (City, town, or county) (State) PENNSYLVANIA			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm. Cook Brooks Towson Inc. ADDRESS 1050 YORK RD. TOWSON, MD 21204	



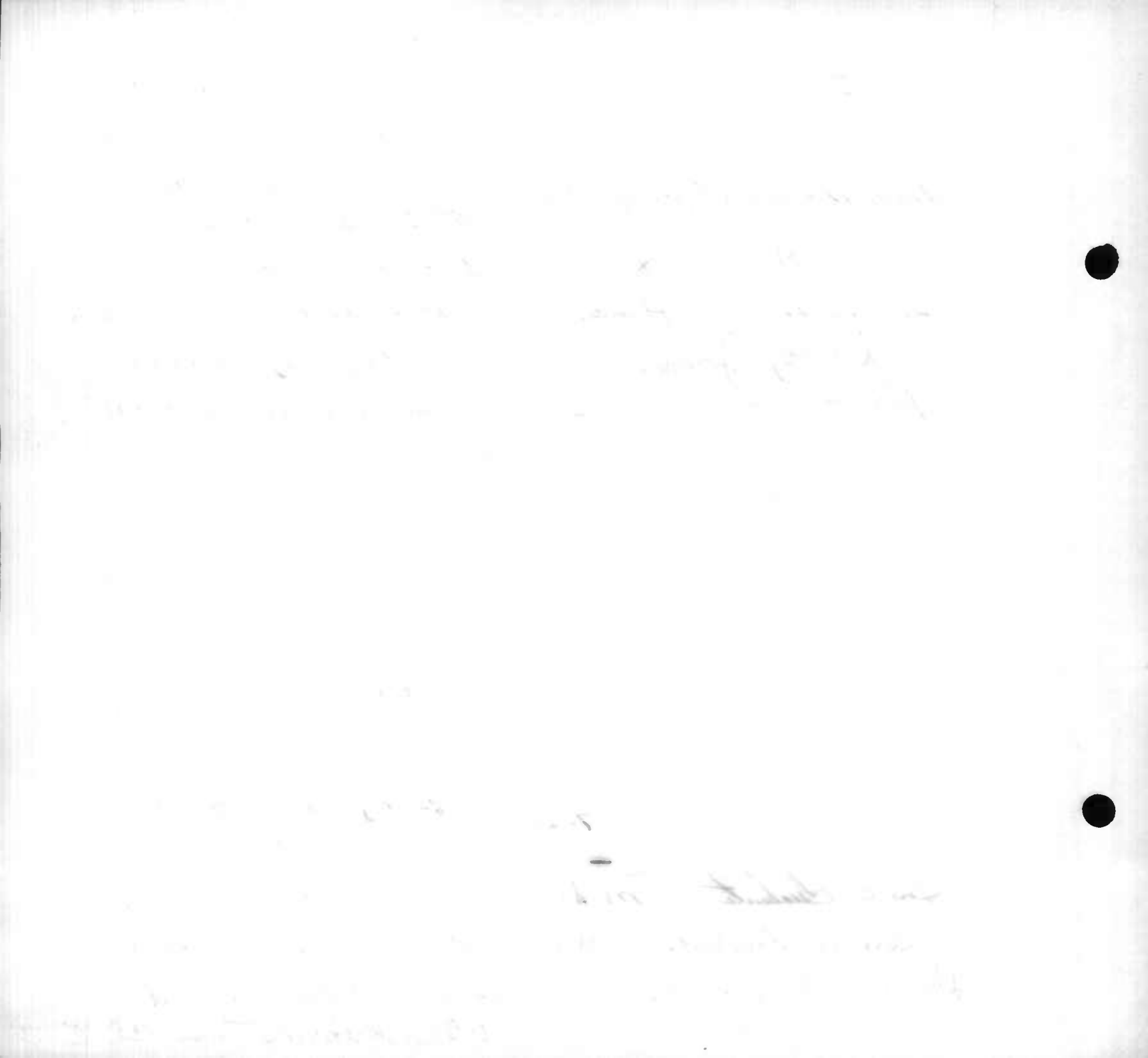
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6791

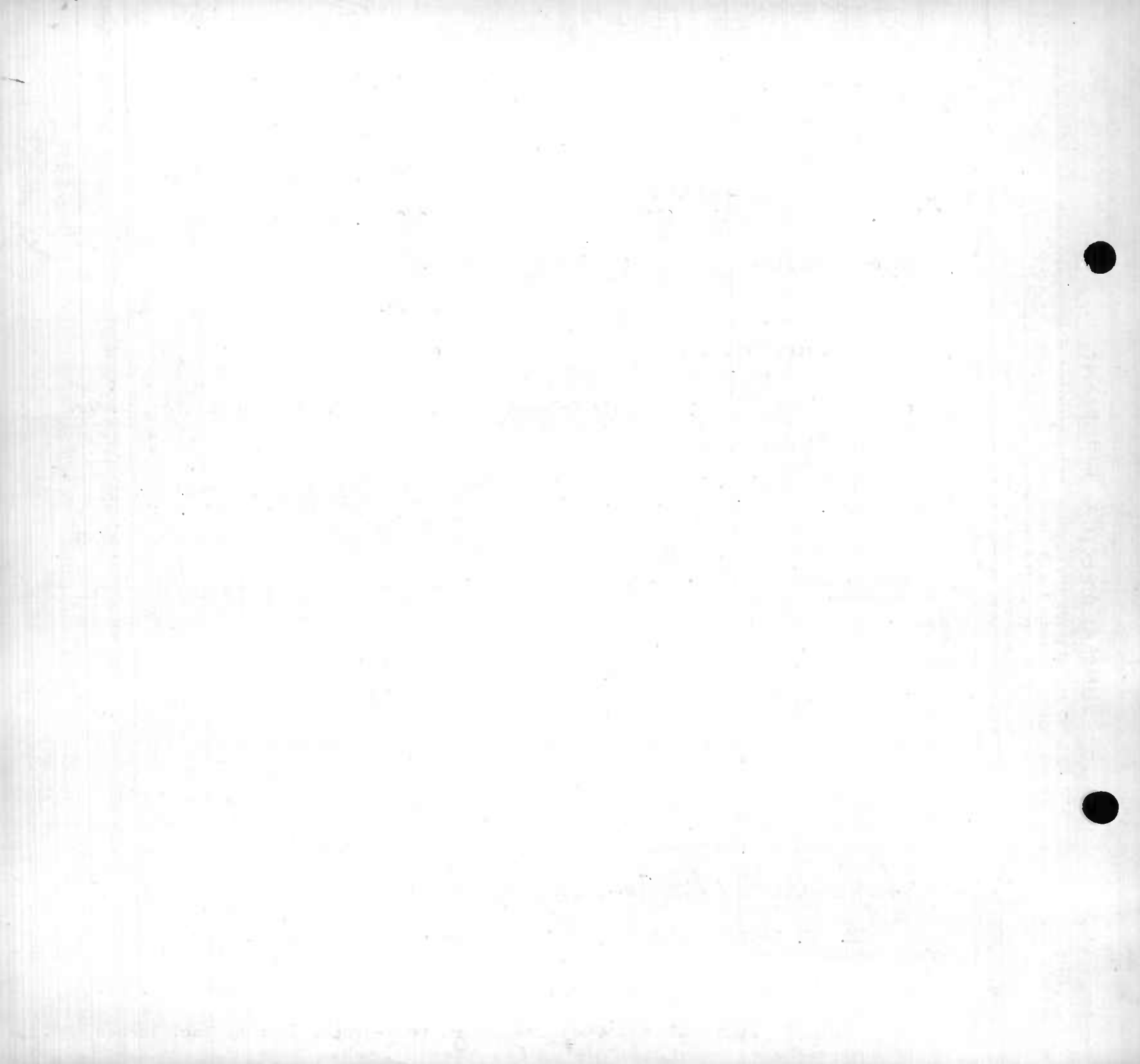
BIRTH NO.		1. NAME OF DECEASED (Type or Print) IRWIN, MABEL R.		2. DATE AND HOUR OF DEATH 7-3-69 8:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		A. STATE MD B. COUNTY Baltimore City			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN City, Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3501 ST. PAUL ST.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-91	9. AGE (In years last birthday) 78	10. Under 1 Tr. Months Days 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home.		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROSS, James		14. MOTHER'S MAIDEN NAME BOWEN, Carrie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Her son, Charles B. IRWIN	
ADDRESS Ellicott city.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 1621 I		CAUSE OF DEATH Cardio-pulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: carcinoma of right lung			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)		D.H.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-18, 1969 to 7-3, 1969 that (I) (we) last saw the deceased alive on 7-2, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose A. Escalante		23B. DATE SIGNED 7-3-69			
23C. PHYSICIAN'S NAME (Type) Jose A. Escalante		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1969		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR W. B. Cook		25C. FUNERAL DIRECTOR W. B. Cook	
ADDRESS 1050 York Rd					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6792	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MCCARTNEY, DAVID		2. DATE AND HOUR OF DEATH July 4, 1969 12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE IN THE PINES -BELVEDERE 2525 W. BELVEDERE AVENUE 21215			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1-1-1992		9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ????		10B. KIND OF BUSINESS OR INDUSTRY ????		11. BIRTHPLACE (State or foreign country) West Va.	
13. FATHER'S NAME Lester McCartney			14. MOTHER'S MAIDEN NAME Rebecca Pryne		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NW I		16. SOCIAL SECURITY NO. 232-22-36-04		17. INFORMANT Tomblyn Fun Chapel, Buckhannon, W. Va.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Obstructive Pulmonary Disease Prostatic Hypertrophy			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 or 2 wks. 1 mo.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 17, 1969 to July 4, 1969 , that (I) (we) last saw the deceased alive on June 17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester Kolman MD				23B. DATE SIGNED July 4, 1969	
23C. PHYSICIAN'S NAME (Type) DR. LESTER KOLMAN		23D. ADDRESS 3700 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-1969		24C. NAME OF CEMETERY or CREMATORY Hamton Cem.	
24D. LOCATION Buckhannon County, W. Va.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson, Md.	



1
C-435

69 6793 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6793

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MATTIE CLAYTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 222 Laurens Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1969 2:45 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission) A. STATE Maryland B. COUNTY 1401	
9. DATE OF BIRTH 8/25/12		10. AGE (In years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Albert Fuller		14. MOTHER'S MAIDEN NAME Luna Bertha Mills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 243-03-3600	
17. CAUSE OF DEATH Cause of death undetermined due to post-mortem decomposition (findings from complete autopsy and toxicological examination were not sufficient to explain death). (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		18. INFORMANT John R. Fuller Selma, North Carolina	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 796.9		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. DATE OF OPERATION 2	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No) Yes	
25. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
27. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED July 3, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/4/69	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
		25C. FUNERAL DIRECTOR William E. Johnson Baltimore, Maryland	

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 10/10/01 BY 60322

REASON: 25X, 25Y, 25Z

DATE 10/10/01 BY 60322

REASON: 25X, 25Y, 25Z

WILLIAM

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6794

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

OSCAR KING

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 30, 1969 11:30 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2201

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

White

Balto.

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Sept. 26, 1913

50 55

E. STREET AND NUMBER

821 N. Eutaw ST.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur King

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Custodian

14B. KIND OF BUSINESS OR INDUSTRY

St. Mary's College

15. MOTHER'S MAIDEN NAME

Daisy A. King Pace

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

?

17. SOCIAL
SECURITY NO.

?

18. INFORMANT

ADDRESS

Daisy A. King, 4729 Belwood Green, Balto, Md.

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Ex.

July 1, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

July 3, 69

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

VS 151-REV. 1/1/68

JUL 7 1969

Werner U. Spitz, M.D.

G. Truman Schwab, 5151 Balto. Natl. Pike, Balt
Maryland, 21229

2000

F 400

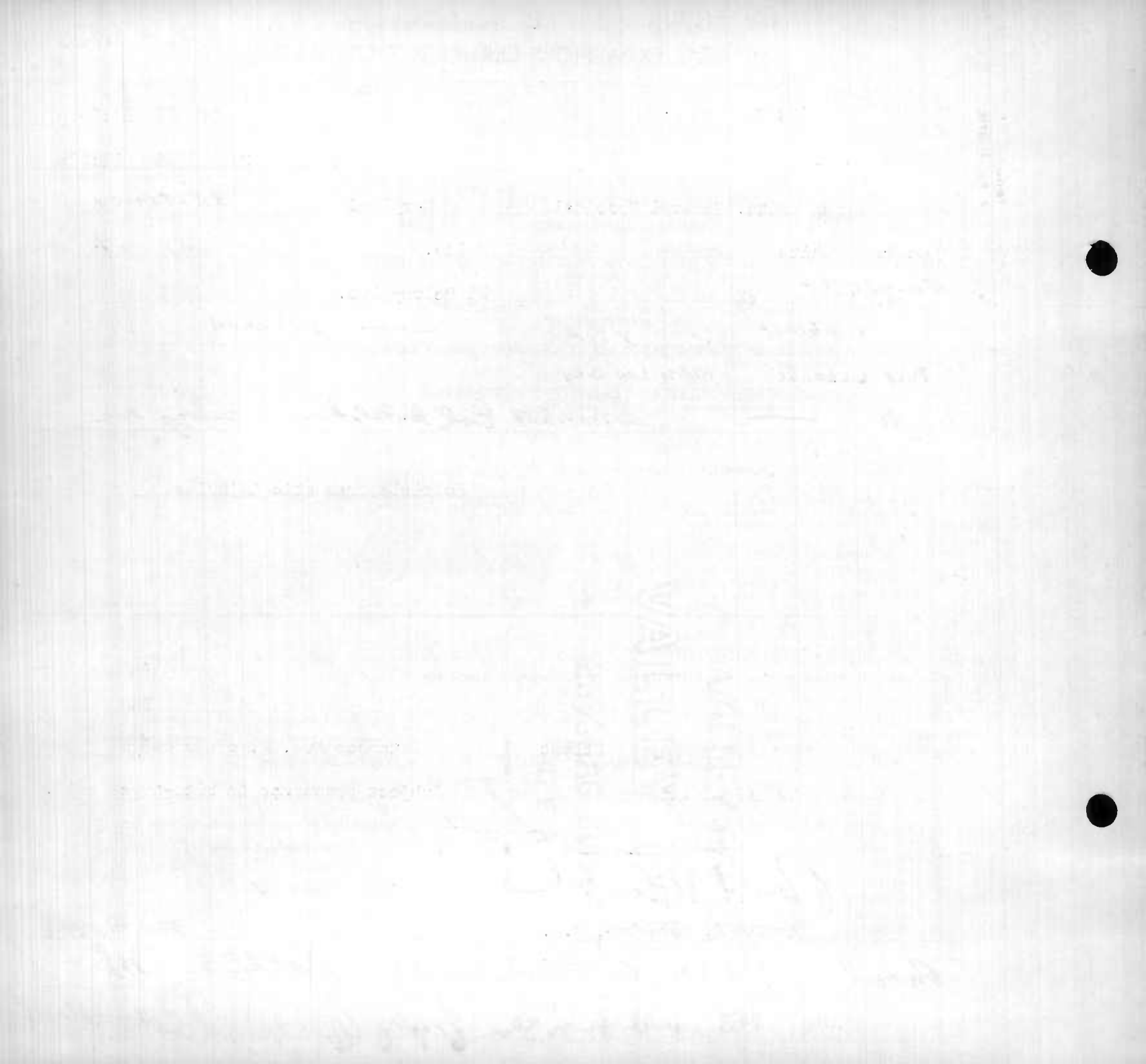
69 6795 BALTIMORE CITY HEALTH DEPARTMENT

69 6795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year		Hour	
		LAVINIA FALAHEE		6		29		69		11:20 p		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month		Day		Year		Hour	
43 South Balto. General Hospital				June		29		1969		11:20 p		M.	
6. SEX		7. RACE		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
9. DATE OF BIRTH		10. AGE (In years lost birthday)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER							
JULY 30, 1906		62				31 Delrey Ave.							
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME							
VIRGINIA				U.S.A.		SAKEMAN							
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME					
DRY CLEANER				KIRMO LAUNDRY									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT				ADDRESS			
No				217-03-658		Earl A. Falahee - 31 Delrey Ave							
19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF:									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:									
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED								21. AUTOPSY? (Yes or No)	
2												YES	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
				Street				Patapsco Ave. E. of Brooklyn 2534					
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED				22F. HOW DID INJURY OCCUR?					
6 29 69 10:15				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Subject passenger in auto-truck coll.					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER									
Ronald N. Kornblum, M.D.				ASSOCIATE MEDICAL EXAMINER									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)					
Burial		7-3-69		Cathedral Cemetery				Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS	
JUL 7 1969				Robert E. Fisher, M.D.				Joseph - Crossough				Catonville Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6796 **CERTIFICATE OF DEATH** X REG. NO. 69 6796

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wanda D. Lyons.</i>		2. DATE AND HOUR OF DEATH <i>June 29, 1969 1:30 P.-M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>91 Montebello State Hospital</i>				A. STATE <i>Md.</i> B. COUNTY <i>Balto Co.</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>8534 Oakleigh Rd.</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-29-24</i>	9. AGE (In years last birthday) <i>45</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	
13. FATHER'S NAME <i>Wesley Gardner</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
14. MOTHER'S MAIDEN NAME <i>Pearl Ferrebee</i>				17. INFORMANT <i>Hospital Chart</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-22-3096</i>		ADDRESS	
18. <i>1977-81</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Adenocarcinoma of liver (metastatic)</i> DUE TO, OR AS A CONSEQUENCE OF:	
				(B) <i>Unknown</i> DUE TO, OR AS A CONSEQUENCE OF:	
				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-26 19 69</i> to <i>6-29 19 69</i> , that (I) (we) lost saw the deceased alive on <i>6-29 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cesar J. Pellerano M.D.</i>				23B. DATE SIGNED <i>6-29-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellerano M.D.</i>				23D. ADDRESS <i>Montebello State Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/69</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Robert C. Altenburg Funeral Home, Inc.</i>	
25D. ADDRESS <i>6009 Harford Rd. - Balto., Md. 21214</i>					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

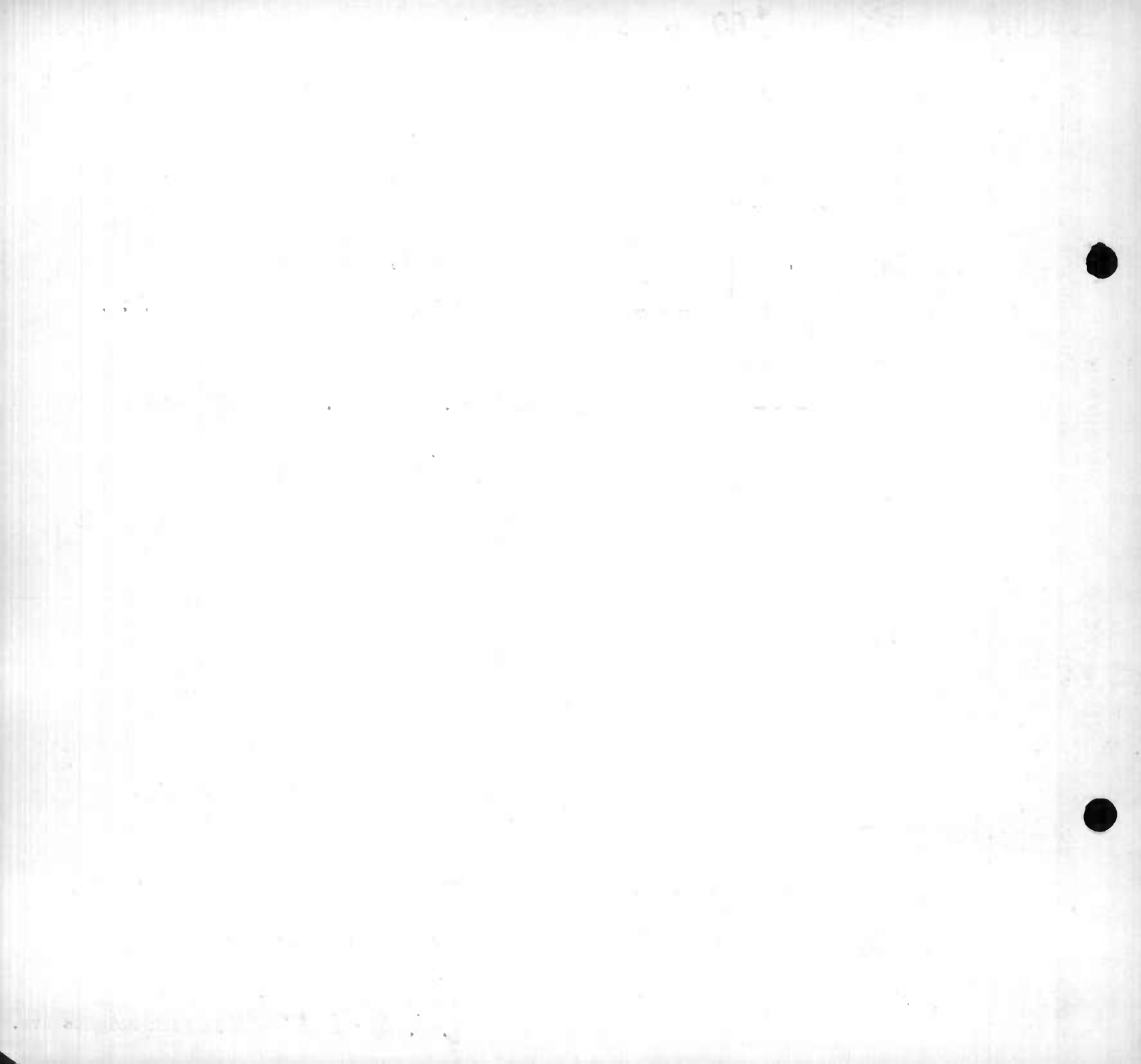
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6797</u>
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>69 6797</u> CERTIFICATE OF DEATH </div>				
1. NAME OF DECEASED (Type or Print) <u>MRS. MARIE LAUTERBAUGH</u>		2. DATE AND HOUR OF DEATH <u>July 2 1969 1845</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u> <u>2025 FAYETTE ST.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>12741</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3807 Cedarhurst Rd. 21206</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1883</u>	9. AGE (In years last birthday) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>
12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. FATHER'S NAME <u>unknown</u>		
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Helen M. Panning - Same</u> ADDRESS <u>—</u>		
18. <u>412.317250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>C.V.A.</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) <u>Generalized arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Atrial fibrillation</u>		
II		<u>Uncontrolled Diabetes Mellitus</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <u>—</u>		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Refused</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>7.1.69</u> to <u>7.2.69</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>7.1.69</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. Abdul Ahmad Qureshi</u>		23B. DATE SIGNED <u>7.2.69</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Abdul Ahmad Qureshi</u>
23D. ADDRESS <u>Bon - Secours Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>7/5/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		25B. NAME OF REGISTRAR <u>John C. Miller, M.D.</u>		25C. FUNERAL DIRECTOR <u>John C. Miller Inc. - 6415 Belair Rd.</u> ADDRESS <u>—</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6798
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Raymond Webster SAUER		July 2, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5229 Reisterstown Road Baltimore, Maryland 21215			A. STATE Maryland		B. COUNTY
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 5229 Reisterstown Road					
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1907	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Service Station		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Otto Sauer			14. MOTHER'S MAIDEN NAME Emma Diener		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 163 03 5542	17. INFORMANT Mrs. Raymond W. Sauer 5229 Reisterstown Road		
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Cor pulmonale (B) CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA 20 yr DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/8/69 to 7/12/69, that (I) (we) last saw the deceased alive on 6/30/69, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Shear M.D.			23B. DATE SIGNED 7/5/69		
23C. PHYSICIAN'S NAME (Type) Joseph Shear M.D.			23D. ADDRESS 6715 Park Heights Avenue		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5 JUL 69		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR E. E. Gable, M.D.		25C. FUNERAL DIRECTOR F. Lowell Lemmon 4611 Park Heights Ave.	

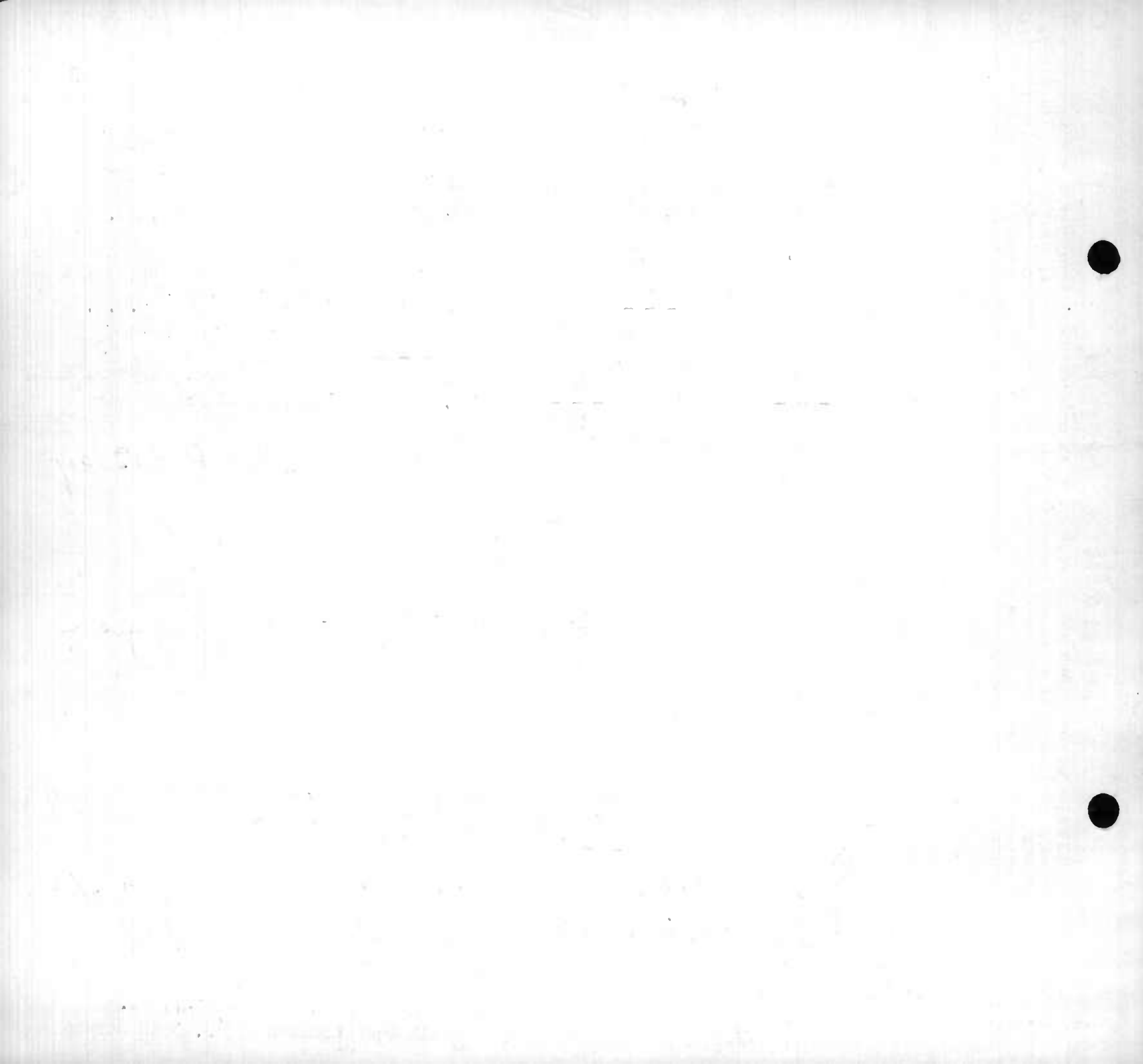


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6799 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 69 6799

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Linda Florence WARD		2. DATE AND HOUR OF DEATH July 4, 1969 10³⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2716		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 4612 Pall Mall Road Jewish Convalescent Home		E. STREET AND NUMBER 4642 Pall Mall Road Baltimore, Md. 21215		5. SEX Female 6. RACE Cauc. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY - - -		8. DATE OF BIRTH 9 AUG 1877 9. AGE (In years last birthday) 91	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME - - - Davis		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO - - -		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Baltimore, Maryland 21207 Mrs. Eunice Files 1542 Clairidge Road		18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Pneumonia Bilateral APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days		19. 9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diverticulitis atelectasis year	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1962 to July 4 1969 and that (I) (we) lost saw the deceased alive on July 3 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph H. Shear M.D.		23B. DATE SIGNED 7/5/69		23C. PHYSICIAN'S NAME (Type) Joseph H. Shear M.D.	
23D. ADDRESS 6715 Paul 1st St Ball 21215		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 JUL 69	
24C. NAME OF CEMETERY or CREMATORY Riverside Memorial Park		24D. LOCATION (City, town, or county) (State) Norfolk, Virginia		25A. DATE REC'D. BY HEALTH DEPT. JUL 7 1969	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Ewe & Williamson		25D. ADDRESS 436 W. 35th Street	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

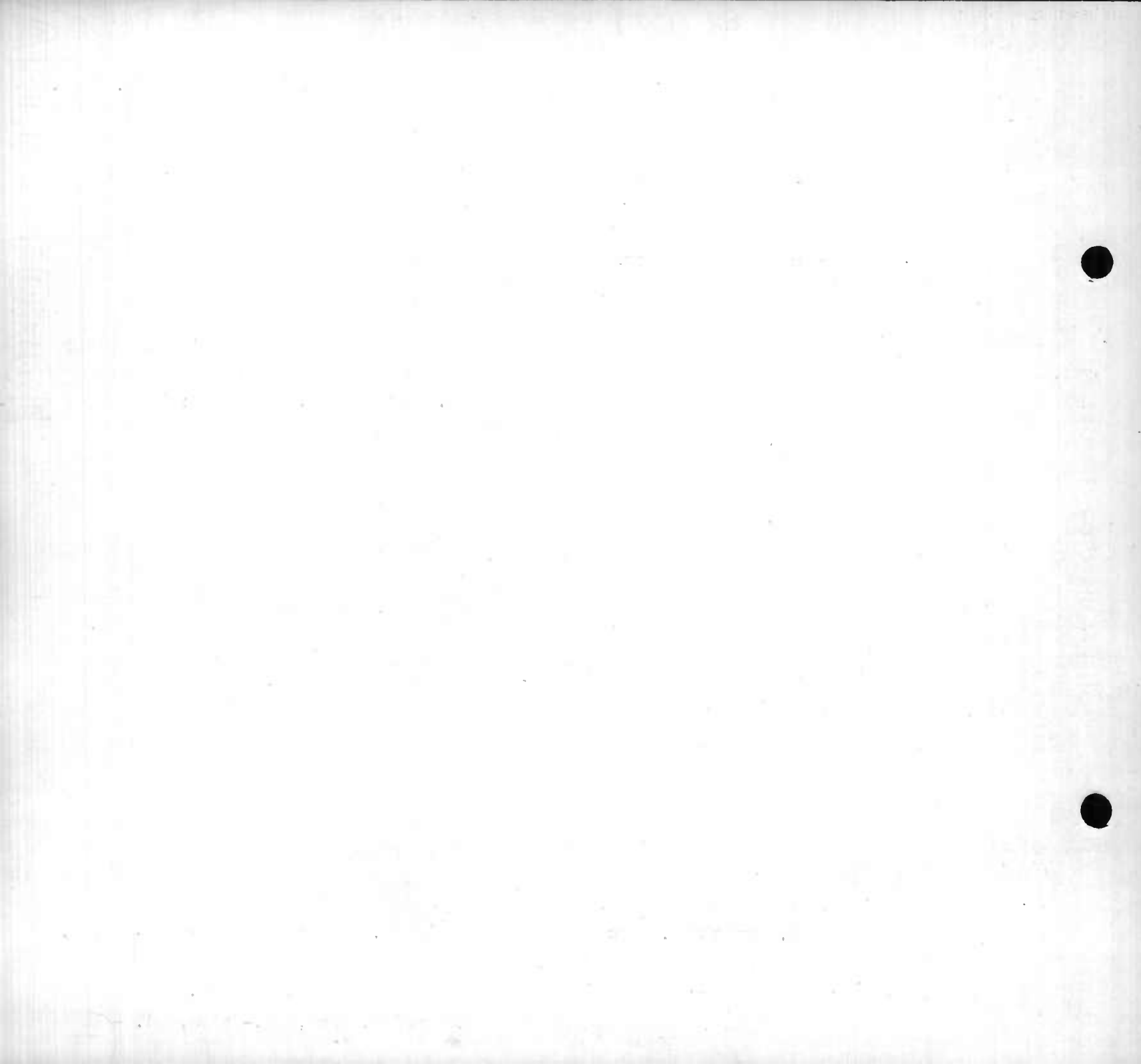
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 69 6800	
BIRTH NO. 69 6800				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARIE L. Schopp				2. DATE AND HOUR OF DEATH July 3, 1969 6.15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 830 KINGSTON Road			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09-09-01	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES OF AMERICA	
13. FATHER'S NAME LOUIS SCHVERHOLZ				14. MOTHER'S MAIDEN NAME ROSIE VAHLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214467923		17. INFORMANT Rose Tignall - Same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma of the Ovaries (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR? _____				21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
22. I certify that (I) (this hospital) attended the deceased from June 24, 1969 to July 3, 1969 that (I) (we) last saw the deceased alive on July 2, 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Mig Karacuschansky				23B. DATE SIGNED July 3, 1969		23C. PHYSICIAN'S NAME (Type) Miguel KARACUSCHANSKY	
23D. ADDRESS Union Memorial Hospital				23E. DEGREE _____			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem,		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR Leonard O. Rick Inc. Balto. Md.		25D. ADDRESS 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6801		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6801	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROSE MASON		July 1, 1969 12.00 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
90 Long Green Nursing Home		Bellona & Melrose Aves.		Maryland 2714	
5. SEX		6. RACE		C. CITY OR TOWN	
female		caucasian		Baltimore	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER	
Housewife				303 Overhill Road	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Anton Rich		Elizabeth Springer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-50-9329		Mrs. Elizabeth M. Sauchelli: 303 Overhill Rd.	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 mo	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ASCVD		yes	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/8/68 19 to 7/2/69 19 that (I) (we) last saw the deceased alive on 6/28/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Francis W. Gluck M.D.				7/2/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Francis W. Gluck				100 W. University Parkway, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/3/69		Parkwood Cemetery	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ZIP CODE	
Baltimore, Md.		Maryland		21204	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 7 1969		Robert E. Taylor, M.D.		Leonard J. Buck, Inc. - Balto, Md. - 14	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6802 CERTIFICATE OF DEATH

REG. NO. 69 6802

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Angela C. Mason</u>		2. DATE AND HOUR OF DEATH <u>7/1/69</u> <u>6:10 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2706</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>2308 Hamilton Avenue</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1897.</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Organist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James A. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Malloy</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-20-5421</u>		17. INFORMANT <u>Miss. Margaret Campbell</u> ADDRESS <u>(Same)</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEMOPERICARDIUM</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Rupture of L VENTRICLE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>AC. CORONARY ARTERIOSCL.</u> (C) <u>C MYOCARDIAL INFARCT</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>75</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> 19 <u>69</u> to <u>7/1</u> 19 <u>69</u> . that (I) (we) lost saw the deceased alive on <u>7/1</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis E. Grenzer</u>		23B. DATE SIGNED <u>7/1/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Louis E. Grenzer</u>	
23D. ADDRESS <u>Md. General Hospital</u>		23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/69.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. STATE <u>Balto. Md.</u>		24F. CITY, TOWN, OR COUNTY	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Leona J. Buck, Inc. Balto. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6803
BIRTH NO.		69 6803		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Thomas, Isabella Wiley		7/2/69		10 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
Maryland General Hosp		A. STATE Md B. COUNTY 2864		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		4416 Old Frederick Rd 21229		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7/7/10	58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper			Virginia	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Thomas Wiley		Ida Carroll		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-05-3022	Mrs. Vida W. Bailey	Wash. D.C.
		hosp. chart		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CA (Liver & bone)		
ANTECEDENT CAUSES		(B) CARCINOMA of Rectum		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 5/25/1969 to 7/2/1969, that (I) (we) last saw the deceased alive on 7/2/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
J. F. Hartman M.D.				7/2/69
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
J. F. HARTMAN M.D.		Md. Gen. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	7/5/69.	Moreland Memorial Cemetery	Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS
JUL 7 1969	Robert E. Taylor, M.D.	Leonard J. Ruck, Inc. Balto. Md.		21214

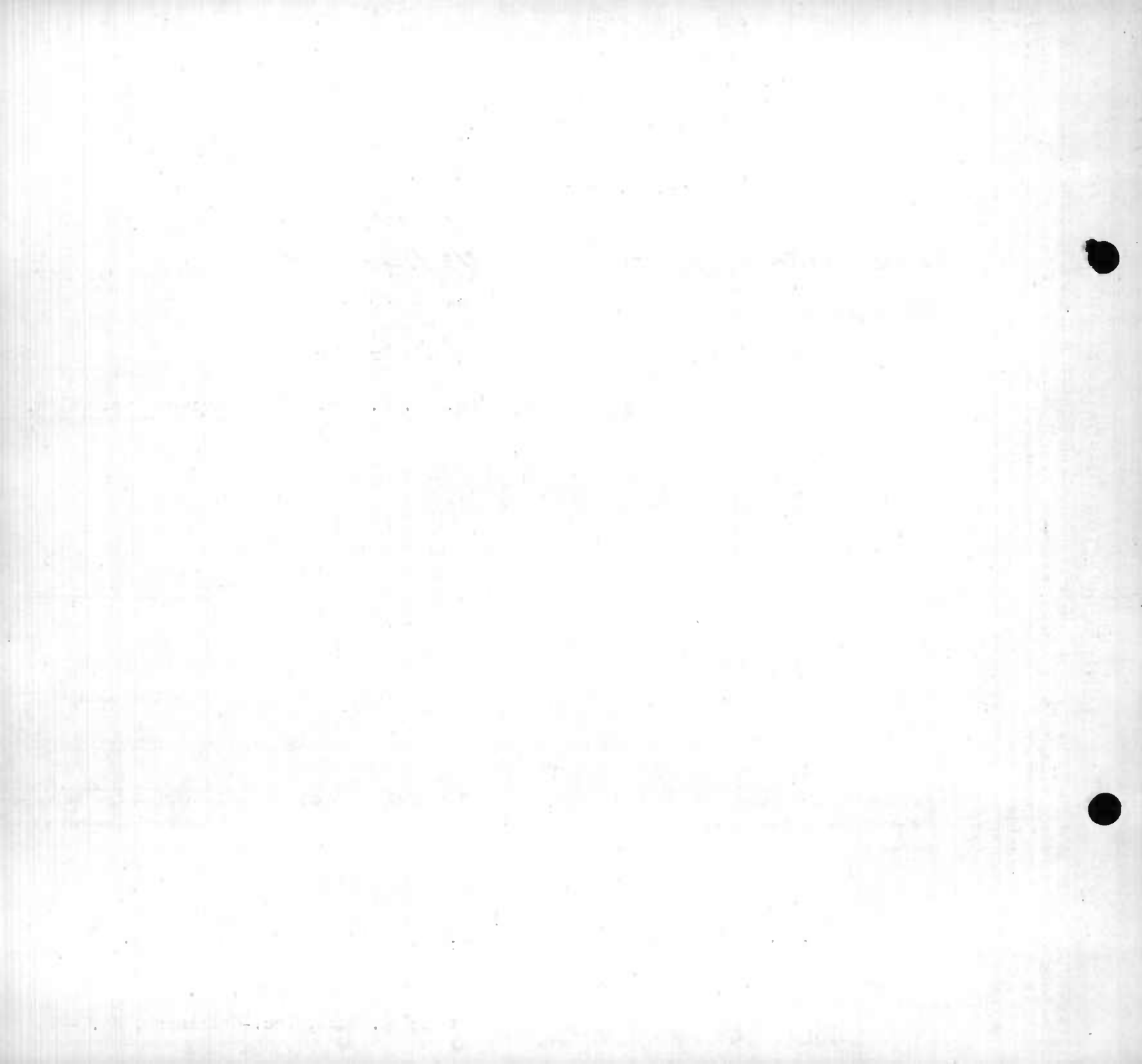
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6804 CERTIFICATE OF DEATH

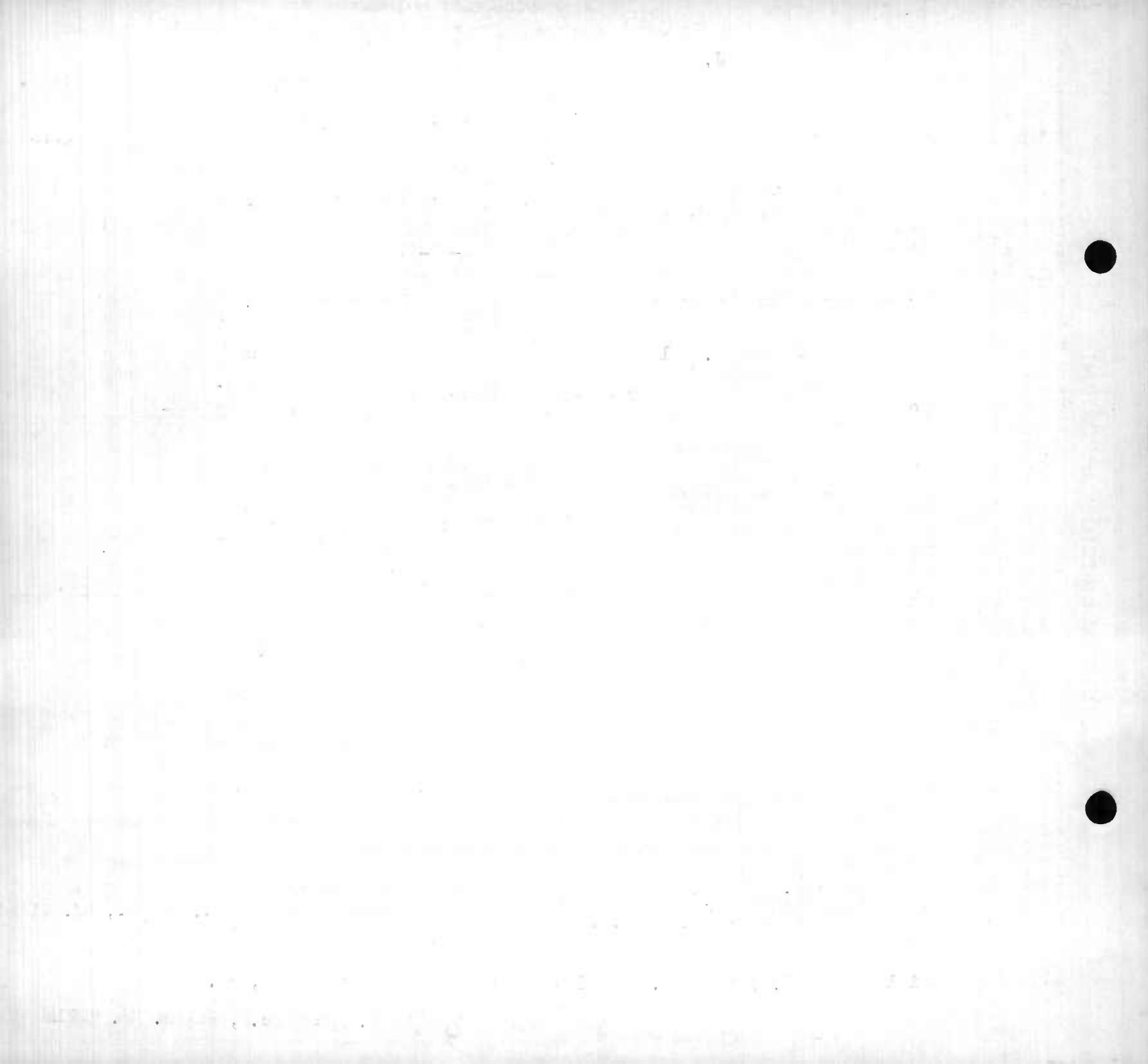
REG. NO. 69 6804

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edith Buler</i>		2. DATE AND HOUR OF DEATH <i>7-2-69 9:55 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2706</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>HARFORD GARDENS CONVALESCENT home</i>			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Female</i>			6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>7/31/1888</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		9. AGE (In years last birthday) <i>80</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William White</i>			14. MOTHER'S MAIDEN NAME <i>Maggie Bradford</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-52-0194</i>		17. INFORMANT <i>Mrs. Wm. F. Rue, 2616 Evergreen Ave, Balto.</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>485X I Bronchopneumonia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-20-1969</i> to <i>July 2-1969</i> , that it (we) lost saw the deceased alive on <i>June 27-1969</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. A. Allan Spier, M.D.</i>				23B. DATE SIGNED <i>7/3/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. A. Allan Spier</i>				23D. ADDRESS <i>1501 Pentridge Road, Balto, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>July 7, 1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>Riverside CEMETERY</i>	
24D. LOCATION (City, town, or county) <i>Norristown, Pa.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1969</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. - Baltimore, Md. - 14</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-400		69 6805		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6805	
BIRTH NO.				J.			
1. NAME OF DECEASED (Type or Print)				Howard Cole			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 7-2-69 2:40P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 20 5300			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 9205 Philadelphia Rd. 21222							
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-31-87	
9. AGE (In years last birthday) 81		If Under 1 Yr. Months: Days: Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barton Duer & Koch Paper Co		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael J. Cole				14. MOTHER'S MAIDEN NAME Emma Burns			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-51-1905A		17. INFORMANT ADDRESS Records: 4940 Eastern Ave. Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 173.91 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cerebrovascular disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Malnutrition and weakness (B) DUE TO, OR AS A CONSEQUENCE OF: Ca. of the Skin and lungs one year (C) _____			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 4th 1969 to July 2nd 1969, that (I) (we) last saw the deceased alive on July 2nd 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fazl Ahmad Foad M.D.				23B. DATE SIGNED July 2nd 1969		23C. PHYSICIAN'S NAME (Type) Fazl Ahmad Foad M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/5/69		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery	
24D. LOCATION Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fabel, M.D.	
25C. FUNERAL DIRECTOR Leonard G. Buck Inc., Balto. Md. 21214				25D. ADDRESS 4940 Eastern Ave., Balto., Md. 21224			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM A. YOUNG

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

June 28, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1017 East Preston Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 28, 1969

3:15 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1001

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1/24/07

10. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1017 East Preston Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Percy C YOUNG

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber

14B. KIND OF BUSINESS OR INDUSTRY

Barber

15. MOTHER'S MAIDEN NAME

Bertha V. Colvin

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

218-03-1535

18. INFORMANT

Steward Turner 1020 Poplar Grove

ADDRESS

19.

5718

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty metamorphosis of liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

July 2, 1969

24C. NAME OF CEMETERY or CREMATORY

Arbut's

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1969

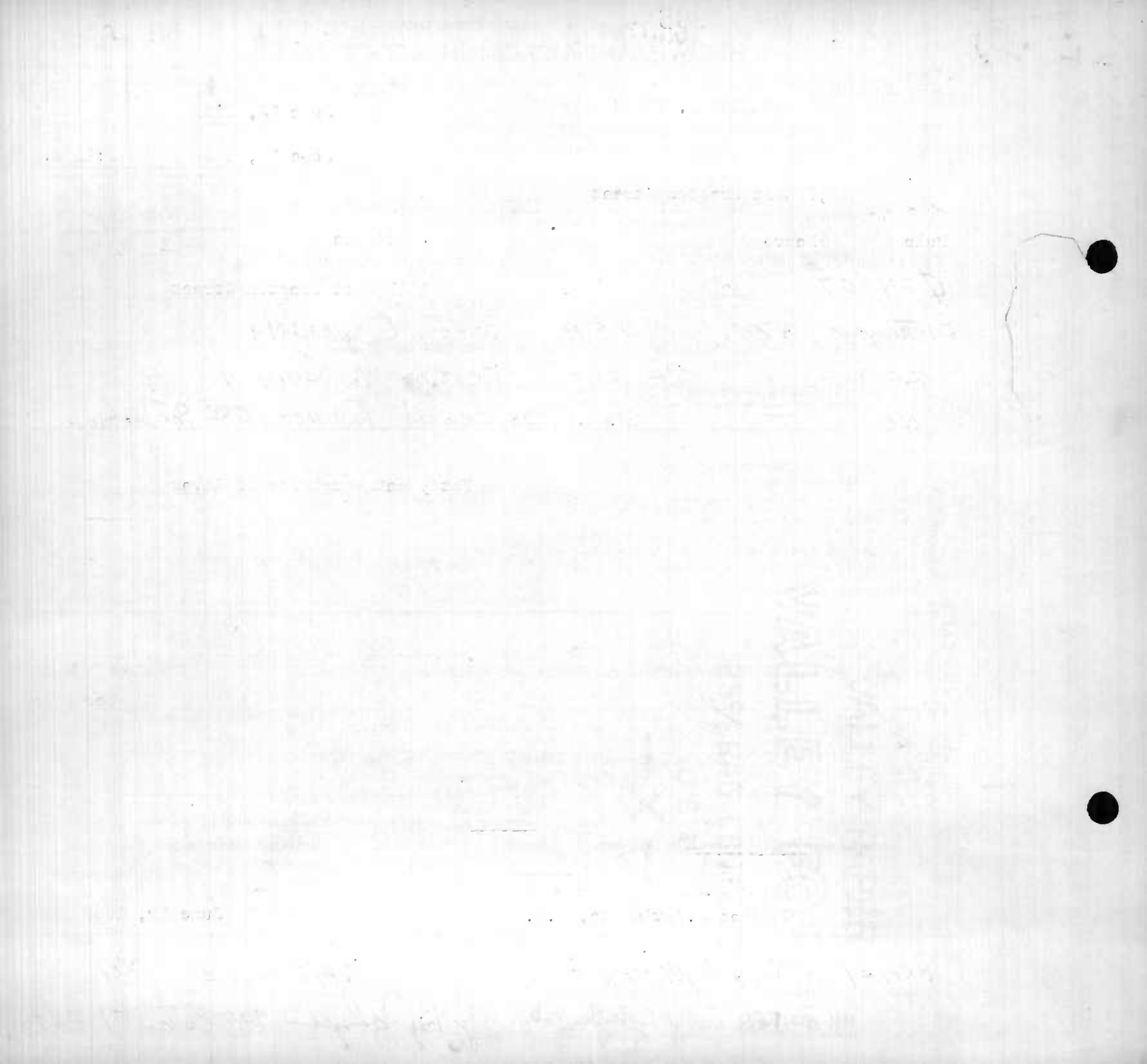
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

J. B. Johnson 1900 Eutan Pl. Baltimore

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

69 6807

REG. NO.

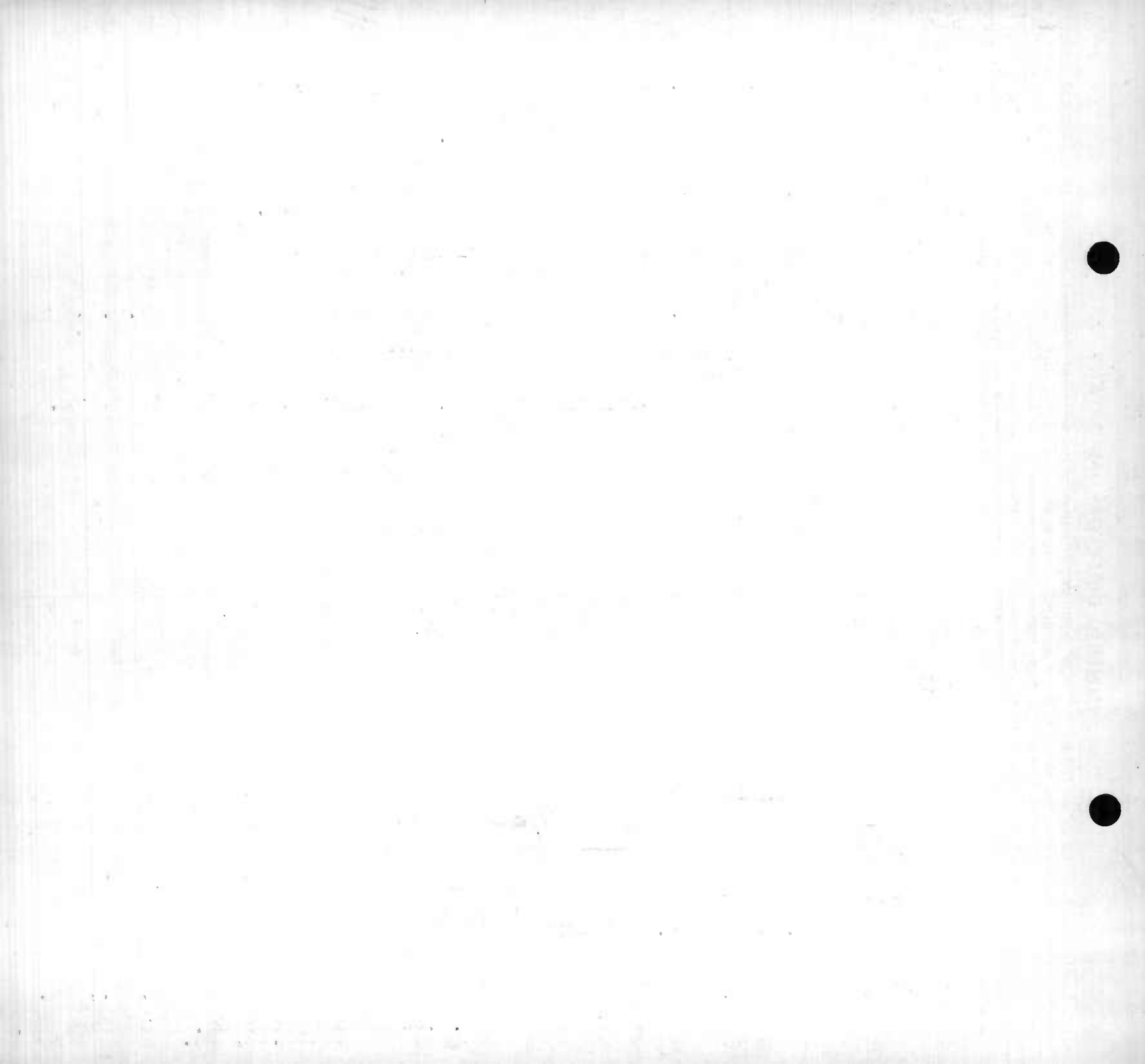
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BELL BAKER TREIDE		2. DATE AND HOUR OF DEATH 7-3-69 9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2711			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 4201 ST. PAUL STREET			
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1883	9. AGE (in years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BUCKEYSTOWN, MD.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME DANIEL BAKER		14. MOTHER'S MAIDEN NAME LILLIE BROTT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No		16. SOCIAL SECURITY NO. 216-46-2004		17. INFORMANT MRS. A.M. HARVEY (SAME)	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION, anterolateral		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 7 hours		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 1969 to July 3 1969 that (I) (we) last saw the deceased alive on July 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE W Leigh Thompson		23B. DATE SIGNED July 3, 1969			
23C. PHYSICIAN'S NAME (Type) W. Leigh Thompson, M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Talbot, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212					



FUNERAL DIRECTOR: IMPORTANT

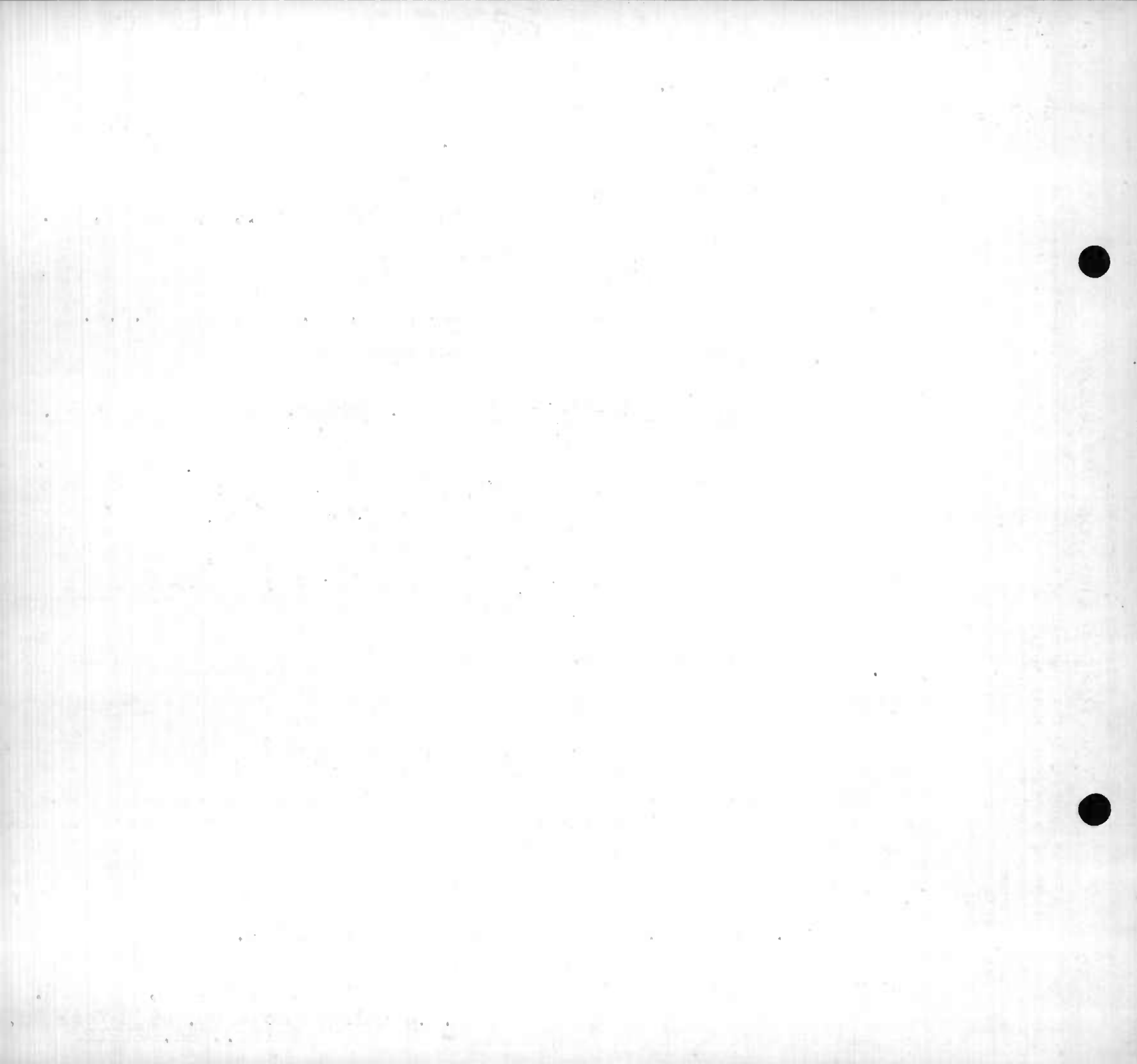
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO.	69 6808
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
		George O. Davies				July 4, 1969 9 ²⁰ A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines Belair Road				A. STATE Md. 2710 C. CITY OR TOWN Baltimore 21212 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 504 Rossiter Ave.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-1889	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Pa. Railroad		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Davies				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 717-07-8542		17. INFORMANT ADDRESS Mrs. Ruth Norton, 504 Rossiter Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4-10-9 I (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) <i>Arteriosclerotic Cardiovascular Disease</i> 73 yrs. (C) <i>Coronary Heart Disease</i> <i>Diagnosed during previous illness</i> <i>Emphysema</i> <i>Chronic Sinus Syndrome</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		20A. AUTOPSY? (Yes or No) No	
22. I certify that (I) (this hospital) attended the deceased from 11/01/1969 to 7/4/1969, that (I) (we) last saw the deceased alive on 7/02/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Albert B. Bradley</i>				23B. DATE SIGNED 7/5/69		23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley	
23D. ADDRESS 4900 Belair Road				23E. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd.		23F. NAME OF REGISTRAR Robert E. Jenkins	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

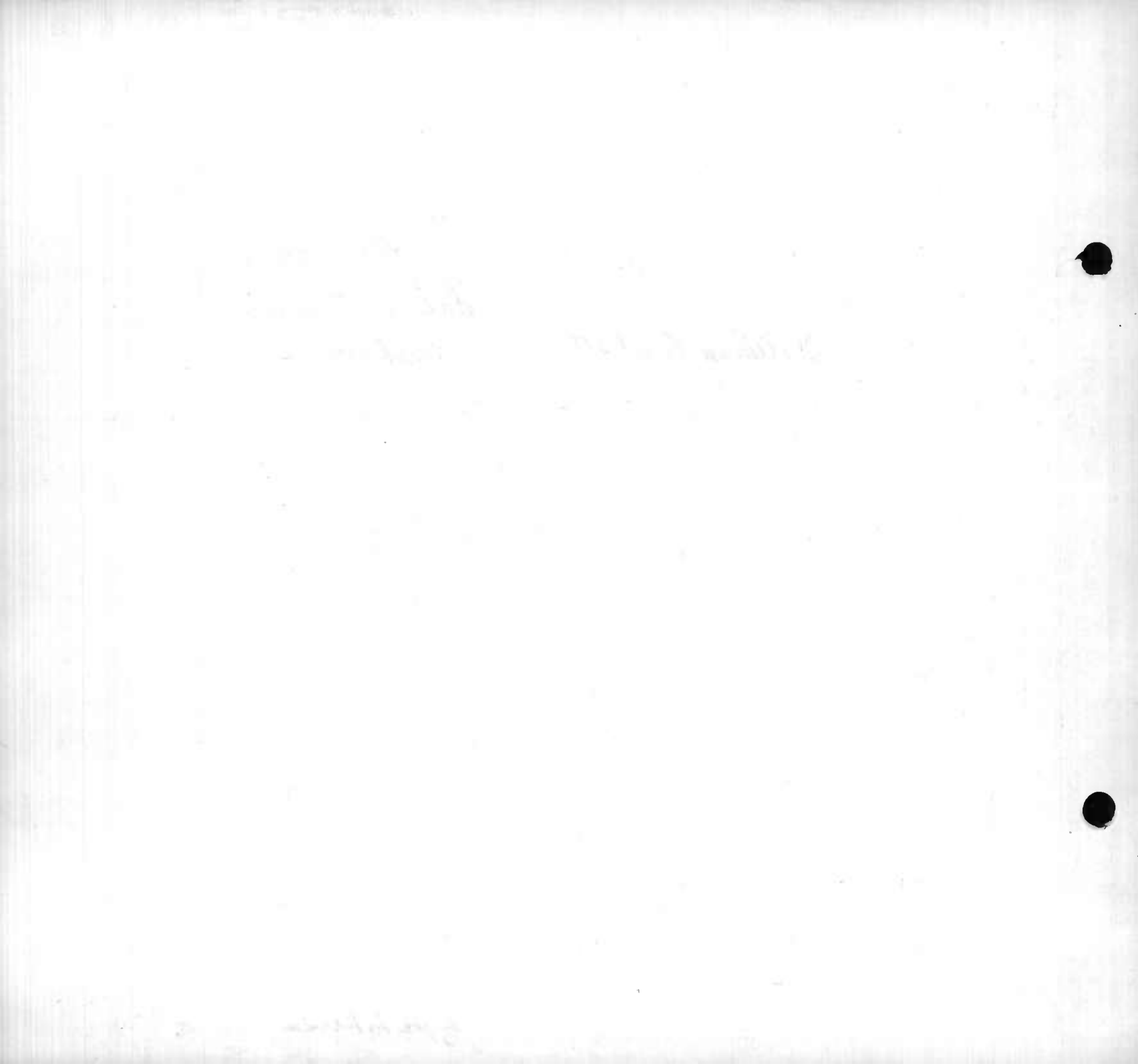
BIRTH NO.		Baltimore City Health Department		REG. NO.	
69 6809		69 6809		69 6809	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Rose M. Childs			July 4, 1969 5:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 5806 Glenkirk Court			A. STATE Md.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN Baltimore 21212		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 329 Paddington Rd., Baltimore, Md.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	M	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1/17/1884	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Housewife			Baltimore, Md.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Own Home			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George W. Andrews			Mary Decoyber		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			213-32-0350		
17. INFORMANT			ADDRESS		
John A. Childs			329 Paddington Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
394.01					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			1. Rheumatic Heart Disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: anterior fibillary septal perforator		
			2. (B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis		
			3. (C) gent / Atherosclerosis		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 1, 1969 to July 4, 1969, that (I) (we) last saw the deceased alive on May 17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. Donald W. Mintzer			July 6 1969		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. Donald W. Mintzer			3007 Evergreen Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/7/69		Woodlawn	
24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Baltimore County, Md.		JUL 7 1969		Robert E. Johnson, Jr.	
25A. DATE REC'D BY HEALTH DEPT.		25C. FUNERAL DIRECTOR		ADDRESS	
		H. W. Jenkins & Sons Co.		4905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

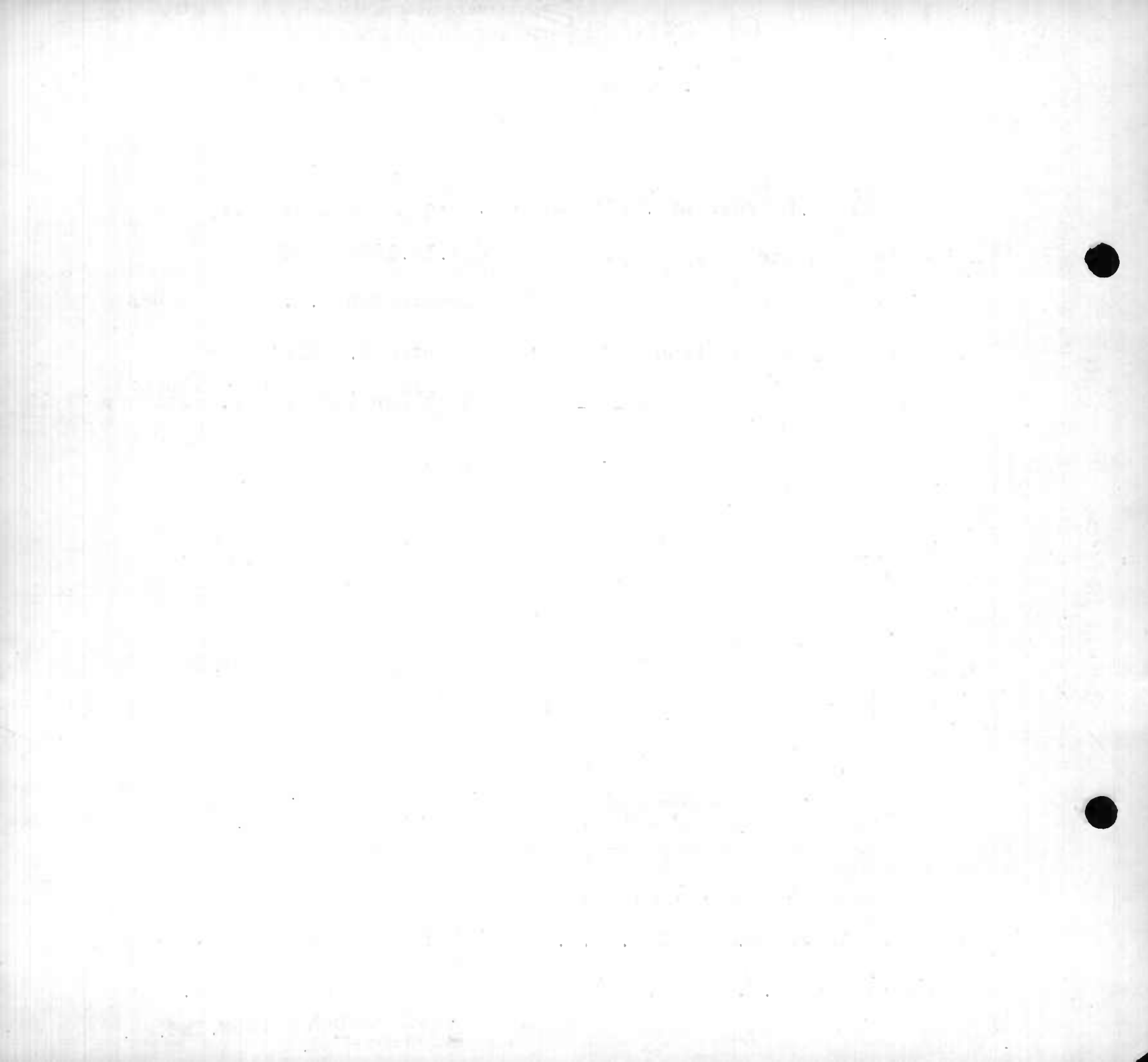
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6810	
BIRTH NO.		69 6810		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Nannie Palmer		July 1, 1969 7 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
70 Maryland Baptist Nursing Home		Maryland		1606	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2801 Raymer Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	Colored	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1870	99	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
Housewife				Salem, Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Abbott		Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		214-56-8451		Nursing Home Records 2801 Raymer Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		10 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1967 to July 1, 1969, that (I) (we) last saw the deceased alive on June 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
William E. Polk		7-3-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William E. Polk		1141 N. Twelfth St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7-5-1969		Mt. Calvary Cemetery	
				Brooklyn Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 7 1969		Robert E. Taylor, D.D.		Joseph E. Kiser	
				2222 W. North Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

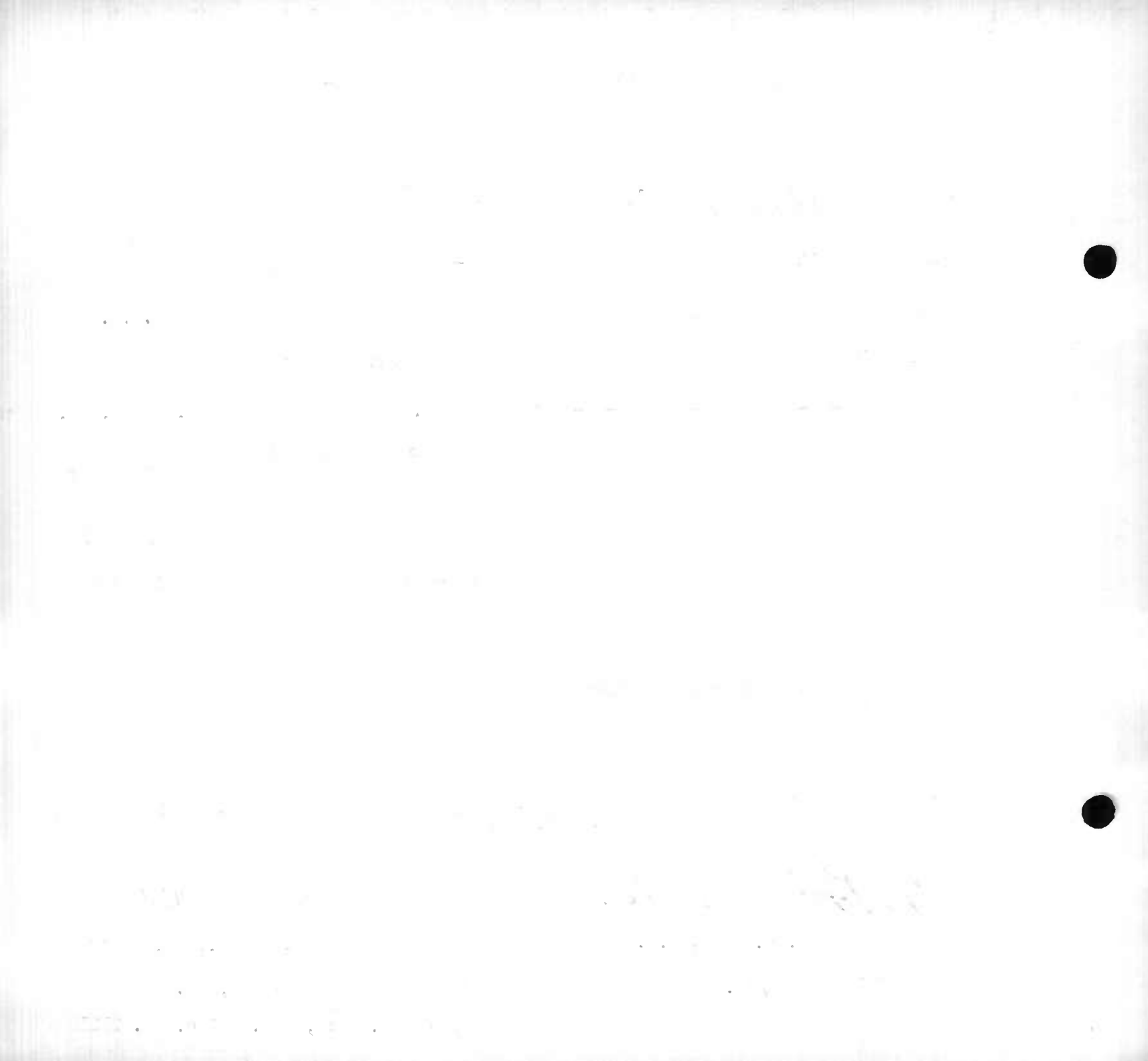
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 6811	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LEONORA M. CROGGON		July 3, 1969 630 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
			B. COUNTY 2712		
90 Long Green Nursing Home 115 E. Melrose Ave. Baltimore Md.			C. CITY OR TOWN Baltimore 21212		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5203 Purlington Way		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10. 1890	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Willard Grove Bolgiano			14. MOTHER'S MAIDEN NAME Martha J. Shields		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-50-8069	17. INFORMANT ADDRESS Charles C. Croggon (Husband) 5203 Purlington Way. Baltimore 21212		
18. 4-12-4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1969 to July 3 1969, that (I) (we) last saw the deceased alive on July 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Fusting			23B. DATE SIGNED July 5, 1969		
23C. PHYSICIAN'S NAME (Type) WILLIAM H. FUSTING, M.D.			23D. ADDRESS 4230 Loch Raven Blvd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 7. 1969	24C. NAME OF CEMETERY or CREMATORY Lorraine Mausoleum		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fusting, M.D.		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC. Baltimore Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 6812		REG. NO. 69 6812	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WALKER, HARRY CORNELIUS				2. DATE AND HOUR OF DEATH 7-1-69 4:20 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2747			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male				6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Retired		8. DATE OF BIRTH 2-7-96		9. AGE (in years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Walker				14. MOTHER'S MAIDEN NAME Alice Wertz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8-21-17 to 6-2-19		16. SOCIAL SECURITY NO. 218-07-0131		17. INFORMANT Records		ADDRESS VA Hosp. 3900 Loch Raven Blvd. Balto. Md. 21211	
18. 15381 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Enterocutaneous fistula				2 months			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF: 12 months			
				(C) Adenocarcinoma of the colon DUE TO, OR AS A CONSEQUENCE OF: 20 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION November 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Colon		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 23 1969 to July 1 1969 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 1 1969 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. B. IAMS, M.D.				23B. DATE SIGNED 7/1/69			
23C. PHYSICIAN'S NAME (Type) W. B. IAMS, M.D.				23D. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/69.		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Buck, Inc.		ADDRESS Balto. Md. 21211	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6813
BIRTH NO.		69 6813		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Julia Jeppi</i>		2. DATE AND HOUR OF DEATH <i>6/30/69</i>		7 ¹⁰ <i>AM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2652</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing Center</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>5407 Barclay's Lane</i>					
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/23/94</i>	9. AGE (In years lost birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Stephen Lamanna</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-0712</i>		17. INFORMANT <i>Admission Record</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>250.91</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cerebral arteriosclerosis</i>		<i>yes</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>arteriosclerosis general</i>		<i>yes</i>	
		(C) <i>Diabetes mellitus</i>		<i>yes</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/5</i> 19 <i>68</i> to <i>6/30</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6/30</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>al Martinus</i>		23B. DATE SIGNED <i>6/30/69</i>		23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>	
23D. ADDRESS <i>2 E Real St Bldg MD 21202</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/3/69</i>	
24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1969</i>	
25B. NAME OF REGISTRAR <i>Robert E. Gable, Reg.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Huck Inc. Balto., Md.</i>		25D. ADDRESS <i>21214</i>	

217-0-112

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
69 6814 CERTIFICATE OF DEATH					REG. NO. 69 6814					
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) CARRIE KOEBLER					2. DATE AND HOUR OF DEATH 6/30/69 6:00 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 90 GOULD CONVALESARIUM					A. STATE Md. B. COUNTY 2744					
					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER 3301 WHITE AVE.					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1886	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph F. Bauer					14. MOTHER'S MAIDEN NAME Anna E. Klein.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 169-20-6835A		17. INFORMANT Harry C. Knapp.			ADDRESS 3301 White Ave.		
18. 590.01-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Chronic Pyelonephritis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus Complicated Heart Failure Chronic Kidney Disease					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Pyelonephritis (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Pyelonephritis (C) DUE TO, OR AS A CONSEQUENCE OF: Chronic Pyelonephritis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 710 days
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/27/69 to 6/30/69 and that (I) (we) last saw the deceased alive on 6/27/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Albert B. Bradley					23B. DATE SIGNED 6/30/69					
23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY M.D.					23D. ADDRESS DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial.		24B. DATE 7/3/69		24C. NAME OF CEMETERY or CREMATORY Moreland Park Mem. Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Leonard J. Ruek, inc.			ADDRESS 5305 Harford Rd.	

FUNERAL DIRECTOR: IMPORTANT

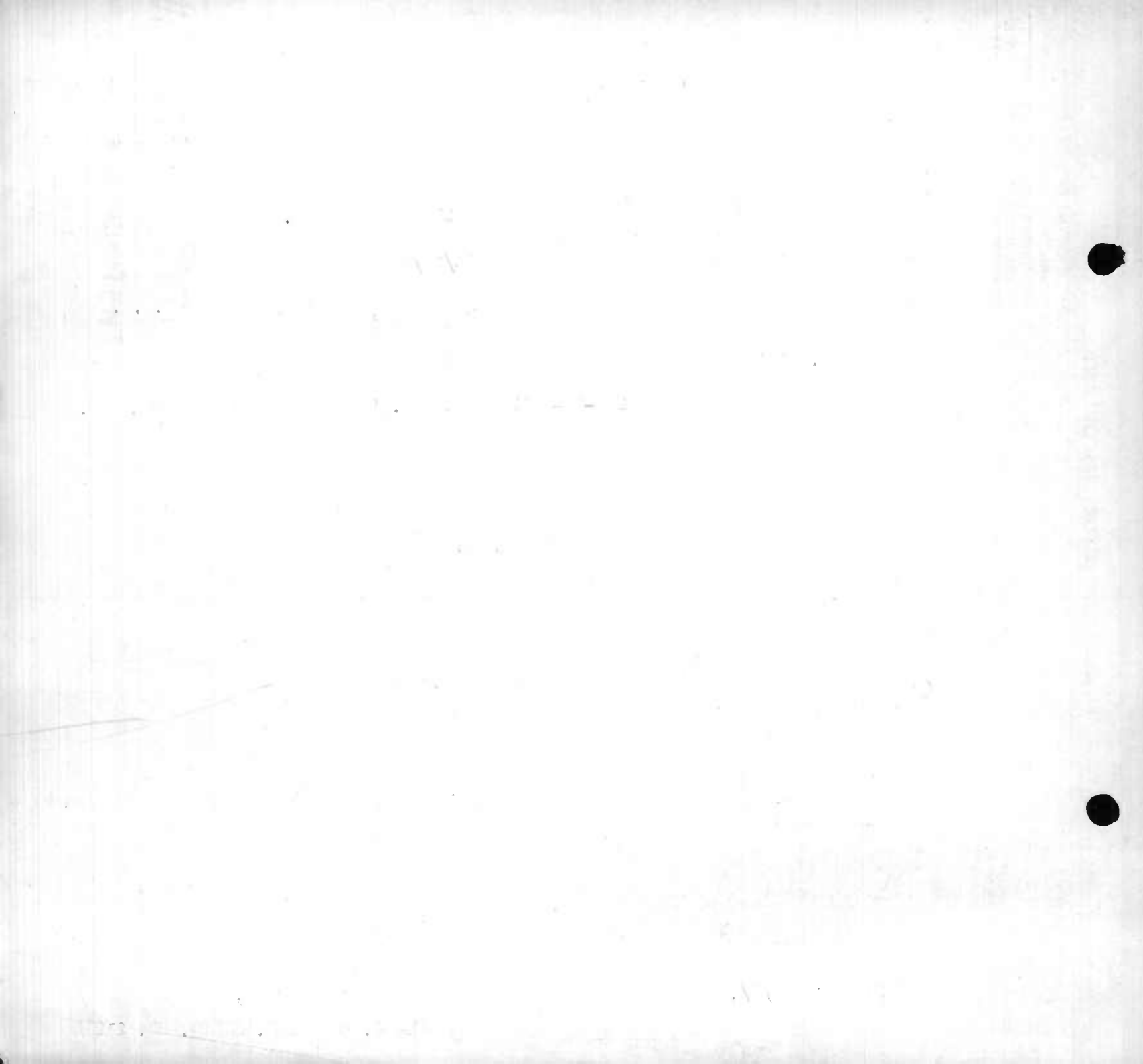
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 6815 CERTIFICATE OF DEATH

REG. NO. 69 6815

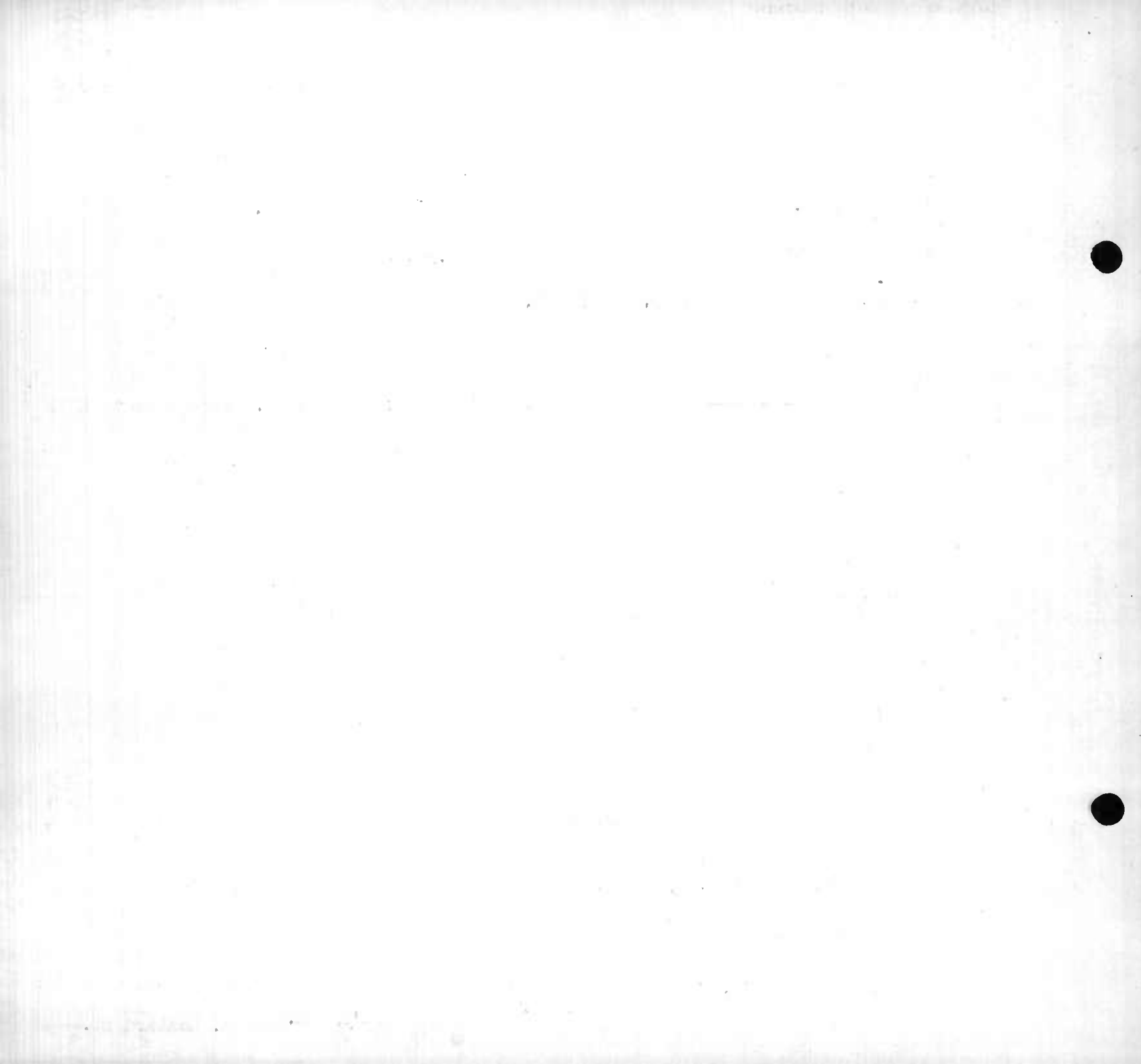
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM LARRY O'PATTERSON		2. DATE AND HOUR OF DEATH 7-1-69 12:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 44 99 UNION MEMORIAL HOSPITAL. D.O.A.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6210 MCLEAN BLVD.		6. DATE OF BIRTH 10/12/20		9. AGE (In years lost birthday) 48	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANICS		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LARRY P. O'PATTERSON		14. MOTHER'S MAIDEN NAME CLARA KERNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-14-4832		17. INFORMANT SADIE G. O'PATTERSON 6210 MCLEAN BLVD.	
18. 7-12-69 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary insufficiency (B) Coronary arteriosclerosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1953 to July 1, 1969 , that (I) (we) last saw the deceased alive on June 2, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R Donald Jandorf		23B. DATE SIGNED 7-2-69		23C. PHYSICIAN'S NAME (Type) R Donald Jandorf	
23D. ADDRESS 7403 Harford Rd		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/69	
24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL CEMETERY		24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		(State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR LEONARD O. BUCK INC. BALTO. MD. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 6816				69 6816	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Adam Senuta		2. DATE AND HOUR OF DEATH July 4, 1969 3:55 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2116 E. Pratt Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 105			
5. SEX male		6. RACE caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Mar. 17, 1889		9. AGE (In years last birthday) 80		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME (unknown)		14. MOTHER'S MAIDEN NAME (unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-5974		17. INFORMANT John Aleksijew ADDRESS 2118 E. Pratt Street 21231	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 58 to July 3 69 and that (I) (we) lost saw the deceased alive on July 3 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry Armanas		23B. DATE SIGNED July 7/69		23C. PHYSICIAN'S NAME (Type) Henry Armanas MD	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE July 7, 69		24C. NAME OF CEMETERY or CREMATORY St Andrews Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969			
25B. NAME OF REGISTRAR James H. D. Dippel		25C. FUNERAL DIRECTOR Dippel Bros. Inc. ADDRESS 1800 E. Lombard St.			

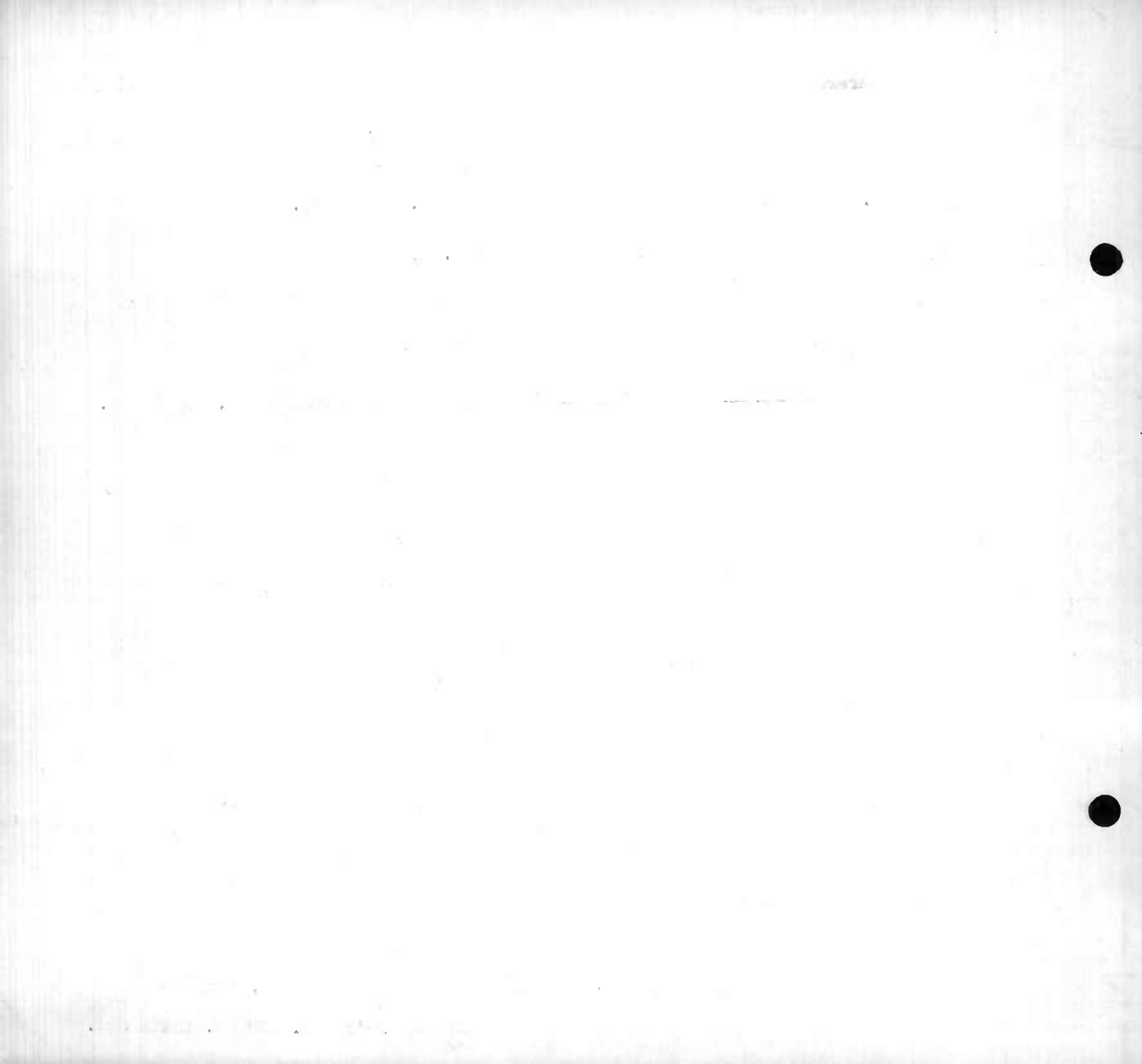


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6817 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 69 6817

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Gerard Charles Feldmann		2. DATE AND HOUR OF DEATH July 6, 1969 7:25 A M M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Maryland B. COUNTY 201		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00106 S. Castle Street		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10B. KIND OF BUSINESS OR INDUSTRY B&O Railroad		8. DATE OF BIRTH Nov. 15, 1898	
13. FATHER'S NAME Joseph Feldmann		14. MOTHER'S MAIDEN NAME Elizabeth Strocke		9. AGE (In years lost birthday) 70	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-3079		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
17. INFORMANT Elizabeth Feldmann		ADDRESS 106 S. Castle St.		12. CITIZEN OF WHAT COUNTRY? USA	
18. 342X I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia		5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Parkinson's Disease DUE TO, OR AS A CONSEQUENCE OF:		years?	
(C) Anterograde cardiac vascular disease				years?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 68 to July 6 19 69 , that (I) (we) last saw the deceased alive on July 5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE George D. Lippy				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) George D. Lippy				23D. ADDRESS 426 S. Patterson St. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 9, 69		24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. DATE REC'D BY HEALTH DEPT. JUL 7 1969		24H. NAME OF REGISTRAR Robert E. Fisher, M.D.		24I. FUNERAL DIRECTOR Dippel Bro's Inc. 1800 E. Lombard St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN SIMONSON (or) Simonsson		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29, 1969 2:25 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 006 N. Broadway		3. DATE PRONOUNCED DEAD Month Day Year June 29, 1969 2:25 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH unknown		10. AGE (In years last birthday) 70 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF USA	
13. FATHER'S NAME unknown		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 301	
15. MOTHER'S MAIDEN NAME unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 128-14-0272		18. INFORMANT Adam C. Mackowski 1725 E. Lombard St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/30/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE July 7, 69	
24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Dippel Bro's Inc. 1800 E. Lombard St.		ADDRESS	

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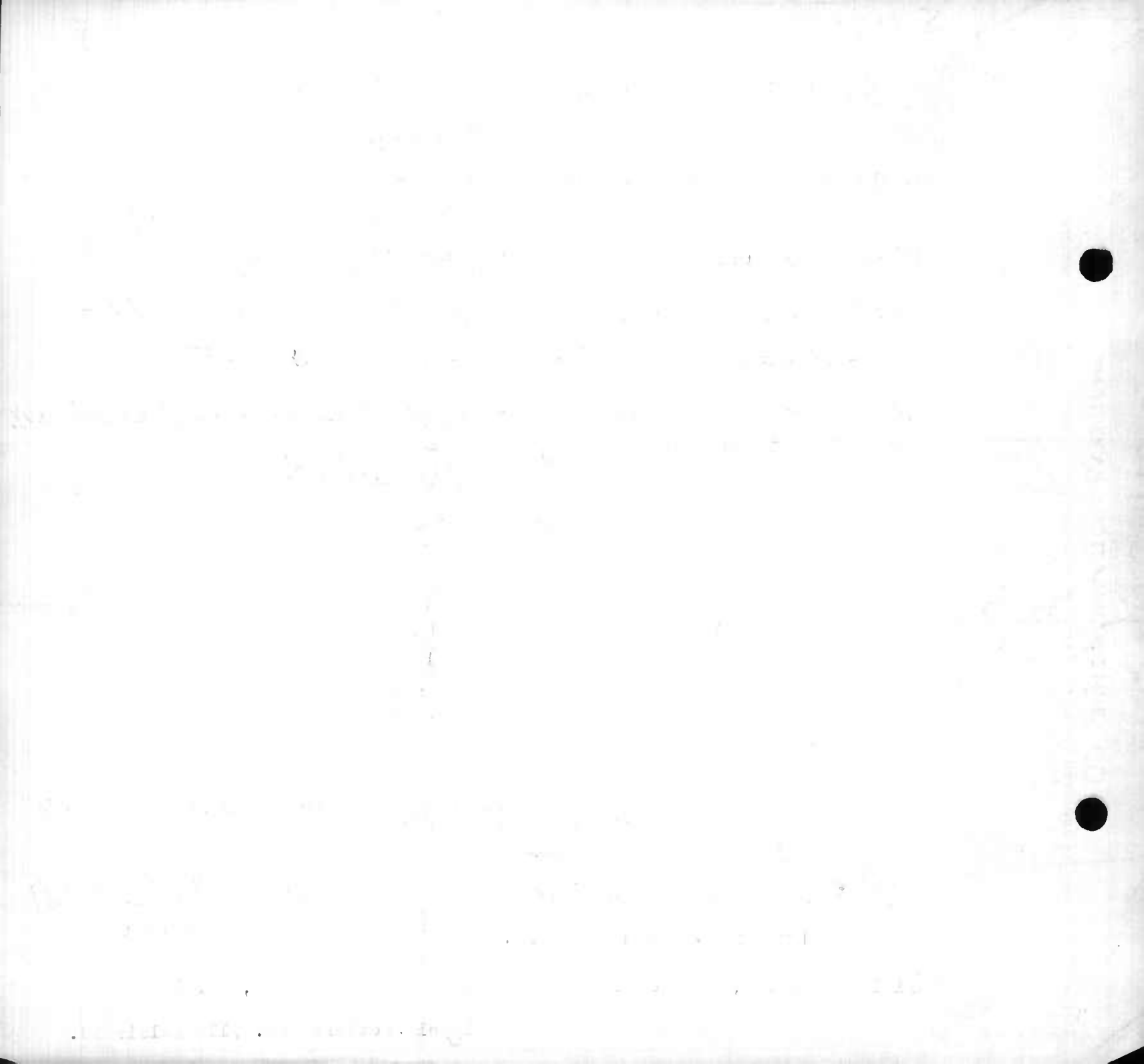
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>5-424</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 6819</u>	
1. NAME OF DECEASED (Type or Print) <u>GEORGE SCHLEGEL</u>		2. DATE AND HOUR OF DEATH <u>7/3/69</u> <u>1345</u> <u>P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>601</u>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>33</u>		E. STREET AND NUMBER <u>3007 PULASKI HIGHWAY</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOV 8 1892</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>	
13. FATHER'S NAME <u>GEORGE SCHLEGEL</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE BENNETT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-10-8677A</u>		17. INFORMANT <u>EDNA STIRLING 3007 PULASKI HWY</u>	
18. <u>4124 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>DEHYDRATION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JULY 3</u> 19 <u>69</u> to <u>JULY 3</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>JULY 3</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard E. Bensinger M.D.</u>		23B. DATE SIGNED <u>July 3, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD E. BENSINGER M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>July 7, 69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Carmel Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Barber, R.D.</u>		25C. FUNERAL DIRECTOR <u>Dipper Brothers Inc. 7110 Belair Rd.</u>			



5-315

69 6820 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6820

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE STEPHENSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 4, 1969 2:23 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1969 2:23 a.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 501			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-28-1899		10. AGE (In years lost birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Seaboard N.C.		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GARDENER		15. MOTHER'S MAIDEN NAME ROXANA ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO. XX XX #1	
18. INFORMANT Bertha STEPHENSON		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz M.D.		DATE SIGNED 7/5/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 7 1969	
24C. NAME OF CEMETERY or CREMATORY BALTO. NAT. Cem.		24D. LOCATION (City, town, or county) (State) 5501 FRED'K AVE	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR Milton E. Elickson		ADDRESS	

10-25-1871
School No.
Voted
Yes 11 = 1

Lucy Stephens
Parker
Dexter Stephens

Board
Edw. H. H. Jan 25th 1871
Wm. C. H. H.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. _____ REG. NO. 69 6821

1. NAME OF DECEASED (Type or Print) MARY BRODNEX (Broadenex)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 30, 1969 8:25 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1969 8:25 A.M.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug. 17, 1897 74		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 74		E. STREET AND NUMBER 1503 Kennsett Avenue	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZENSHIP U.S.A.	
14A. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 241-62-7832	
18. INFORMANT Henry Broadenex		ADDRESS 224 N. Monroe St.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/30/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69	
24C. NAME OF CEMETERY or CREMATORY Roanoke Chapel		24D. LOCATION (City, town, or county) (State) Jackson, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 N. Calhoun St.	

VS 151-REV. 1/1/68

WIA

ALL COUNTY

W. BROWN

W. BROWN

W. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

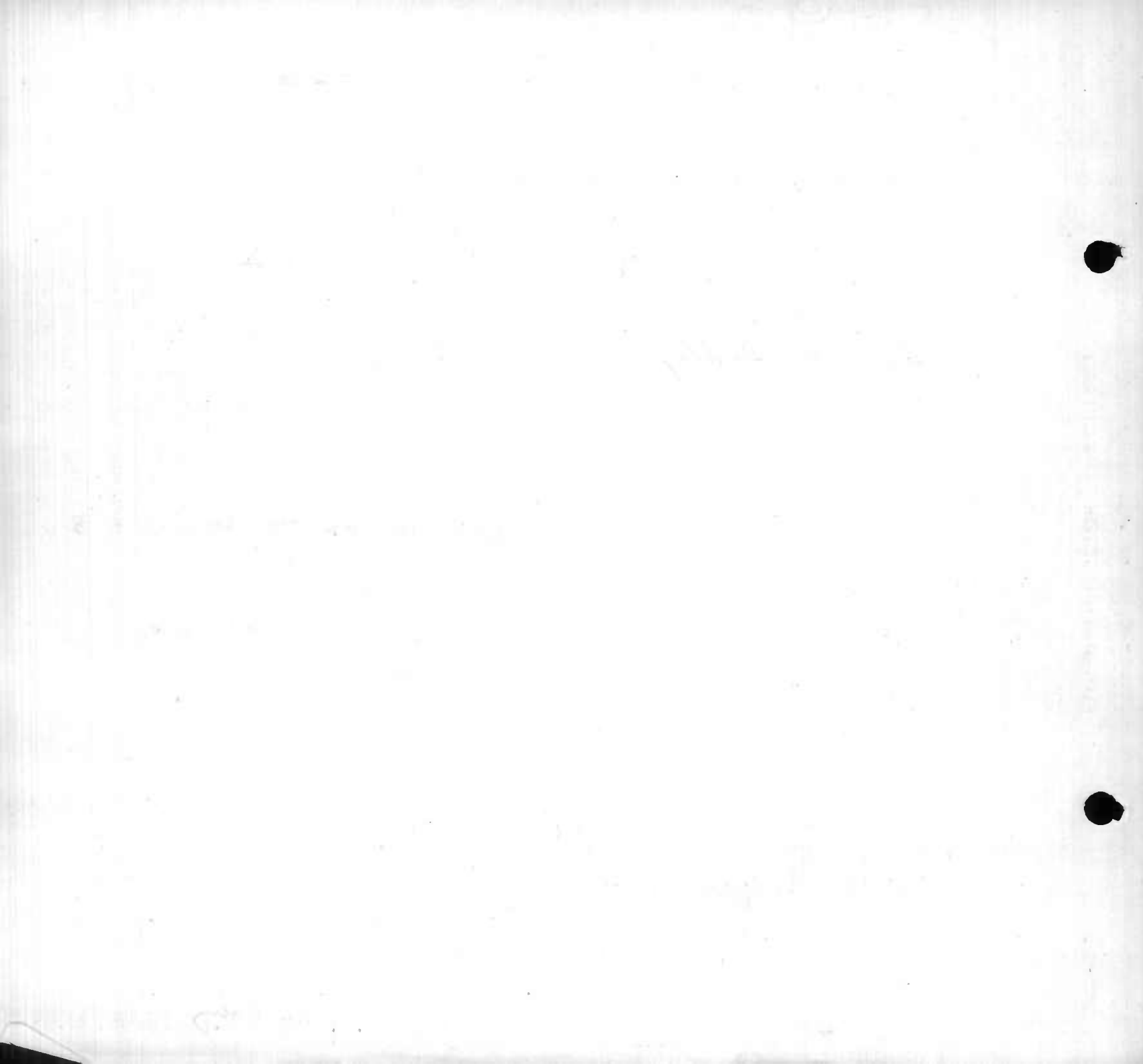
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6822</u>	
P-500		69 6822		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ALICE PENN</u>		2. DATE AND HOUR OF DEATH <u>7/1/69</u> <u>1055 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>501</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1/17/20</u>		9. AGE (in years last birthday) <u>49</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HENRY ECERY</u>		14. MOTHER'S MAIDEN NAME <u>ROSE HARTWIT</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>539-05-8503</u>		17. INFORMANT <u>BOBBIE PENN 3520 Virginia Ave.</u>	
18. <u>402X1</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intracerebral Hemorrhage</u>		<u>4 1/2 hr</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Severe Hypertension</u>		<u>10 yrs</u>	
		(C) <u>Hypertensive Heart Disease</u>		<u>24 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Anticoagulation Therapy</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert J. Rosensteel</u>		23B. DATE SIGNED <u>7/2/69</u>		23C. PHYSICIAN'S NAME (Type) <u>ROBERT J. ROSENSTEEL</u>	
23D. ADDRESS <u>MERCY HOSPITAL</u>		23E. DEGREE <u>M.D.</u>		23F. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/7/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Cem.</u>	
24D. LOCATION <u>Arbutus, Balto. Co., Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
24G. FUNERAL DIRECTOR <u>V.R. Bailey</u>		24H. ADDRESS <u>1348 N. Calhoun St.</u>		24I. REGISTRAR'S SIGNATURE <u>Kelson F.H.</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6823
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MARGARET FRENCH		7-3-69		12:55 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
LUTHERAN HOSPITAL OF MD.		MD. - 1403		
46		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		1831 ETTING ST.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
F	N	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-10-1886	82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED.		-	VIR.	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Albert Dudley		Sarah		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No			Edith Green 1641 Gwynns Falls Pkwy	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		S HOCK		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CARCINOMA OF THE PANCREAS 3 ⁺ WK DUE TO, OR AS A CONSEQUENCE OF:		
		(C).....		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		RIGHT BUNDLE BRANCH BLOCK.		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3-6-27-69	CA HEAD PANCREAS	YES.		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-14-1969 to 7-3-1969, that (I) (we) last saw the deceased alive on 7-3-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED	
Sunan Vongkasemsiri			7-3-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
SUNAN VONGKASEMSIRI		LUTHERAN HOSP. OF MD		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	7/8/69	Church Cem. Gloucester	Gloucester Co., Virginia	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
JUL 7 1969	Robert F. Bailey	Kelson F.H. 1348 N. Calhoun St.		



FUNERAL DIRECTOR: IMPORTANT

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F-432 69 6824		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6824	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FIELDS James Clayton		2. DATE AND HOUR OF DEATH 7/4/69 1 37 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1602		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		E. STREET AND NUMBER 528 N. Carey St.		6. DATE OF BIRTH 10-9-06 7. AGE (in years lost birthday) 62 8. If Under 1 Yr. Months: Days: Hours: Min. 62	
9. SEX M	10. RACE N	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME Joseph		14. MOTHER'S MAIDEN NAME Lucy Ann?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT WIFE (MARY)		ADDRESS	
18. 203 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory & Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia, Lobar DUE TO, OR AS A CONSEQUENCE OF: (C) Multiple Myeloma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS HRS 6 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Spinal Cord Involvement at T6		MONTHS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-20 19 69 to 7-4 19 69 that (I) (we) last saw the deceased alive on 7-4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald M. Wood, M.D.		23B. DATE SIGNED 7-4-69		23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-69		24C. NAME OF CEMETERY or CREMATORY Arbutus M. C.	
24D. LOCATION (City, town, or county) (State) Arbutus, Md.		25A. DATE MADE BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR W. R. Bailey		25D. ADDRESS 1401 FUNERAL HOME BYRON CALHOUN ST			



FUNERAL DIRECTOR: IMPORTANT

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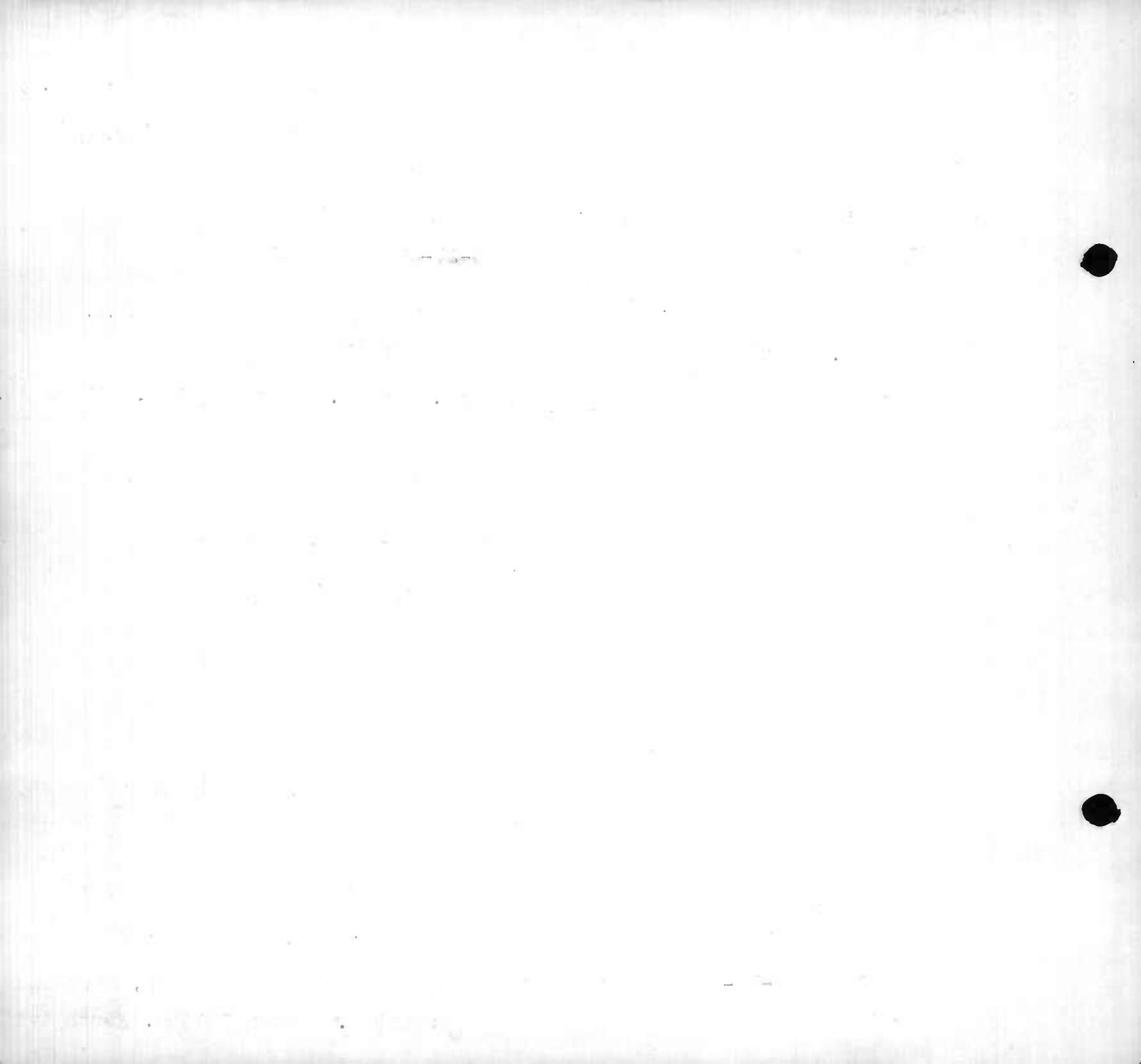
Baltimore City Health Department				REG. NO. 68 6825	
BIRTH NO. C-615		69 6825		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CARPENTER, Lucy</u>		2. DATE AND HOUR OF DEATH <u>7/1/69</u> <u>5:00PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>33 THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>909</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-1911</u> 9. AGE (in years last birthday) <u>58</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Northway Co., Va.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Irving Carpenter 1521 N. Eden St.</u>	
18. <u>410.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>XXXX NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1969</u> to <u>July 1, 1969</u> and that (I) (we) last saw the deceased alive on <u>July 1, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Loren George Lipson, M.D.</u>		23B. DATE SIGNED <u>July 1, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>LOREN GEORGE LIPSON, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-5-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Paul J. Glick 2431 E. Oliver St.</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6826
BIRTH NO. P-362		69 6826 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) PETERS, Lynn ood		2. DATE AND HOUR OF DEATH July 6, 1969 4:40 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Ctr. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2006		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 247 Hilton Avenue 21228		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-07	9. AGE (In years lost birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Coal Company		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME David H. Peters		14. MOTHER'S MAIDEN NAME Lucy Veney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-0586		17. INFORMANT Mrs. Dora D. Peters ADDRESS 247 S. Hilton St.
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular disease 6/7/69 (B) arteriosclerosis, generalized years (C) chronic bronchopneumonia years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/25 1969 to 7/6 1969 , that (I) (we) last saw the deceased alive on 7/6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Alan H. Macht MD		23B. DATE SIGNED 7/6/69		23C. PHYSICIAN'S NAME (Type) ALAN H. MACHT MD
		23D. ADDRESS 2 E Red St Baltimore 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-10-69	24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Herbert E. Nutter ADDRESS 3035 W. North Ave



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6827

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KIRKLAND TAYLOR

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July

4,

1969

6:15 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

yes

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

Yes ☐No ☐

9. DATE OF BIRTH

2-24-48

10. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3212 Virginia Avenue

27-16

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Daniel Taylor

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Good Humor Ice Cream Co.

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ruth Downino

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

218-44-6241

18. INFORMANT

Mrs. Ruth Taylor

ADDRESS

3212 Virginia Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Asphyxia
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hanging
DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Jail cell

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Cell #356 Baltimore City Jail

1003

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) ? ? m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Hanged self

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-7-69

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

(City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1969

25B. NAME OF REGISTRAR

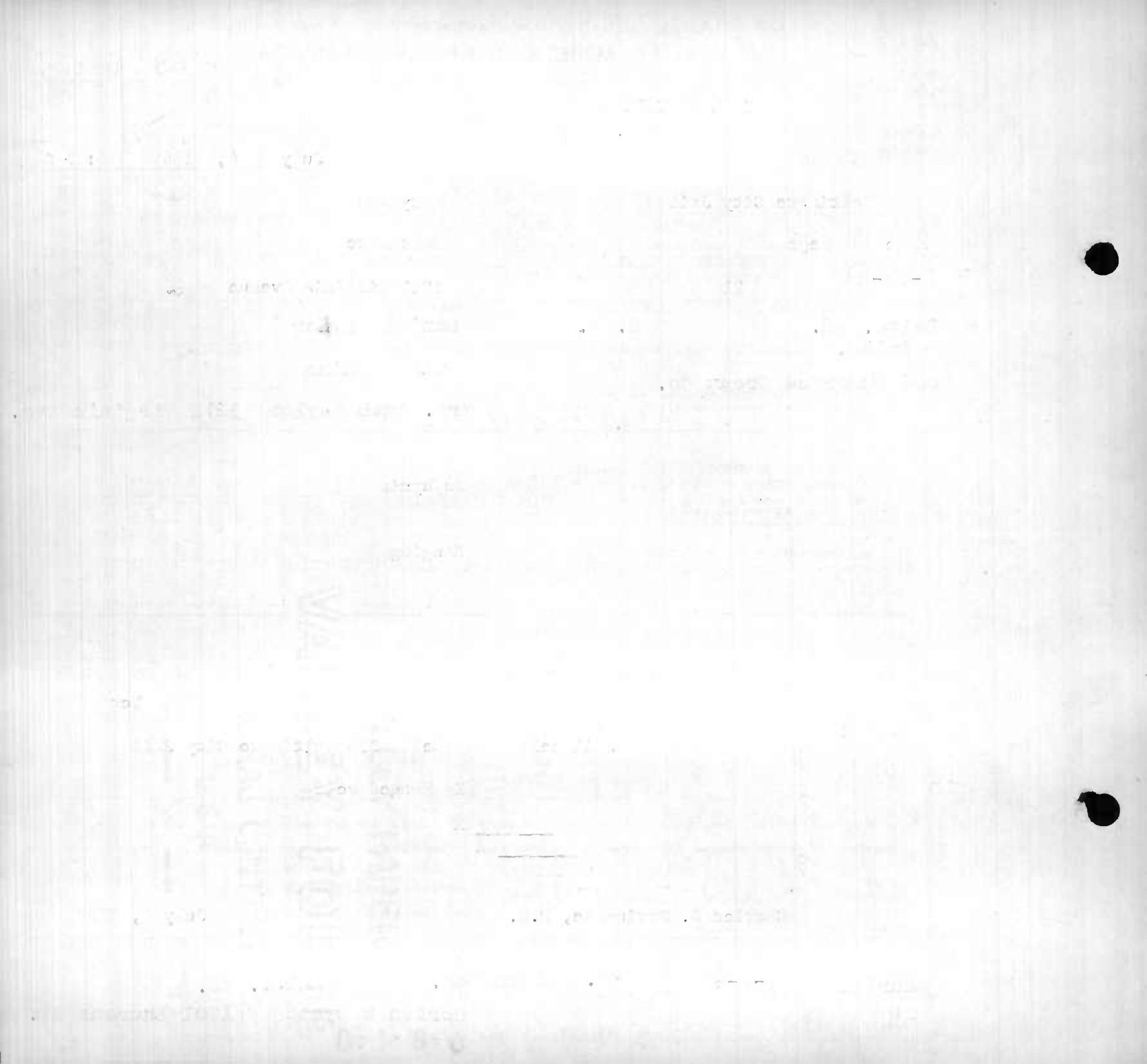
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Morton & Dyett

ADDRESS

1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. 69 6828	
BIRTH NO. H-616			69 6828		
1. NAME OF DECEASED (Type or Print) James W. Harper			2. DATE AND HOUR OF DEATH 7-5-69 6:20P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland 21229			A. STATE B. COUNTY Maryland 21229		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 105 N. Kossuth Street		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-11	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Costodian			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Goldsboro N. C.
12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME Lonnie Harper			14. MOTHER'S MAIDEN NAME Lillie Branch		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 229-18-8494		17. INFORMANT ADDRESS Mrs. Myrtle Harper 105 Kossuth Street
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Tumoral cadaveria			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 2 years.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple myeloma		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 6 1969 to July 6 1969 that (I) (we) last saw the deceased alive on July 6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALEXANDER MEJIA MD			23B. DATE SIGNED July 7/69		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS St Agnes Hosp. Caton & Wilkens Aves		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-9-69		24C. NAME of CEMETERY or CREMATORY EMMANUEL CEMETERY	
24D. LOCATION (City, town, or county) (State) Chester town Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. Feltz, Jr.		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett 1701 Laurens St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6829 CERTIFICATE OF DEATH

REG. NO. 69 6829

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Violet, Rooker</i>		2. DATE AND HOUR OF DEATH <i>7-5-69 18:50 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balte. Co.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>201 Cedar Lane</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/26/03</i>	9. AGE (in years last birthday) <i>65</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Howard Hines</i>		14. MOTHER'S MAIDEN NAME <i>Leona Nicholson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>913-10-1712-D</i>		17. INFORMANT ADDRESS	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>acute Pulmonary edema with atelectasis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (t) (this hospital) attended the deceased from <i>7-1</i> 19 <i>69</i> to <i>7-5</i> 19 <i>69</i> that (t) (we) lost saw the deceased alive on <i>7-5</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lilia C. Baldonado</i> DEGREE				23B. DATE SIGNED <i>7-5-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>LILIA C. BALDONADO</i> DEGREE		23D. ADDRESS <i>SOUTH BALTO. GEN. Hosp. 3001 SOUTH HANOVER BALTO MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7-9-69</i>	24C. NAME OF CEMETERY OR CREMATORY <i>MT. Calvary Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Cedar Hill Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Galt</i>		25C. FUNERAL DIRECTOR <i>Charles O. Wilson</i> ADDRESS <i>1000 Brantley Ave.</i>	

Geiger H111

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6830

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BEN COOPER JR		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> July 1, 1969		3. DATE OF DEATH Month Day Year Hour July 1, 1969 3:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 1504		6. SEX Male 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH March 23, 1950		10. AGE (In years lost birthday) 19		11. BIRTHPLACE (State or foreign country) Burlington, S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ben Cooper Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Elizabeth Addison		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, dates of service) No		17. SOCIAL SECURITY NO. 217-54-4556	
18. INFORMANT Ben Cooper Sr. Son		19. CAUSE OF DEATH 345.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Epilepsy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/2/69					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) Cont		24E. FUNERAL DIRECTOR [Signature]		24F. ADDRESS [Signature]	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1969		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR [Signature]	

Letter from M.E.'s office

1-13-70 M.H.

ACADEMY OF ARTS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6831

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SILAS ROBINSON

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)
OR INSTITUTION

00 1635 E. North Ave.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 30, 1969 4:28 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

806

6. SEX

Male

7. RACE

Colored

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)
78If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1635 E. North Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner July 1, 1969

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-5-69

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION

(City, town, or county)

(State)

Adams County Md

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1969

25B. NAME OF REGISTRAR

Robert E. Fahey, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Elroy Wilson 1000 Crantley

111

70

Out. O'Connell
Bryant's

June 7-27

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6832

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thomas Estelle</i>		2. DATE AND HOUR OF DEATH <i>7/5/69 12:11 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1802</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lt Coln Memorial Nursing Home</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>9027 N Carey St</i>				E. STREET AND NUMBER <i>27 N. Carey St</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/14/00</i>	9. AGE (In years lost birthday) <i>78</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>	
13. FATHER'S NAME <i>Unknown</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>240-224140-D</i>	
17. INFORMANT				ADDRESS	
18. <i>4/10/91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-27</i> 19 <i>69</i> to <i>7-5</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>7-5</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Seunarine</i>				23B. DATE SIGNED <i>7-5-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. SEUNARINE, HOLDS MD.</i>				23D. ADDRESS <i>2425 EUTAW Rd.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-8-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1969</i>			
25B. NAME OF REGISTRAR <i>Robert E. Wigdon</i>		25C. FUNERAL DIRECTOR ADDRESS <i>E. O. Wigdon 1000 BRANTLEY Ave</i>			

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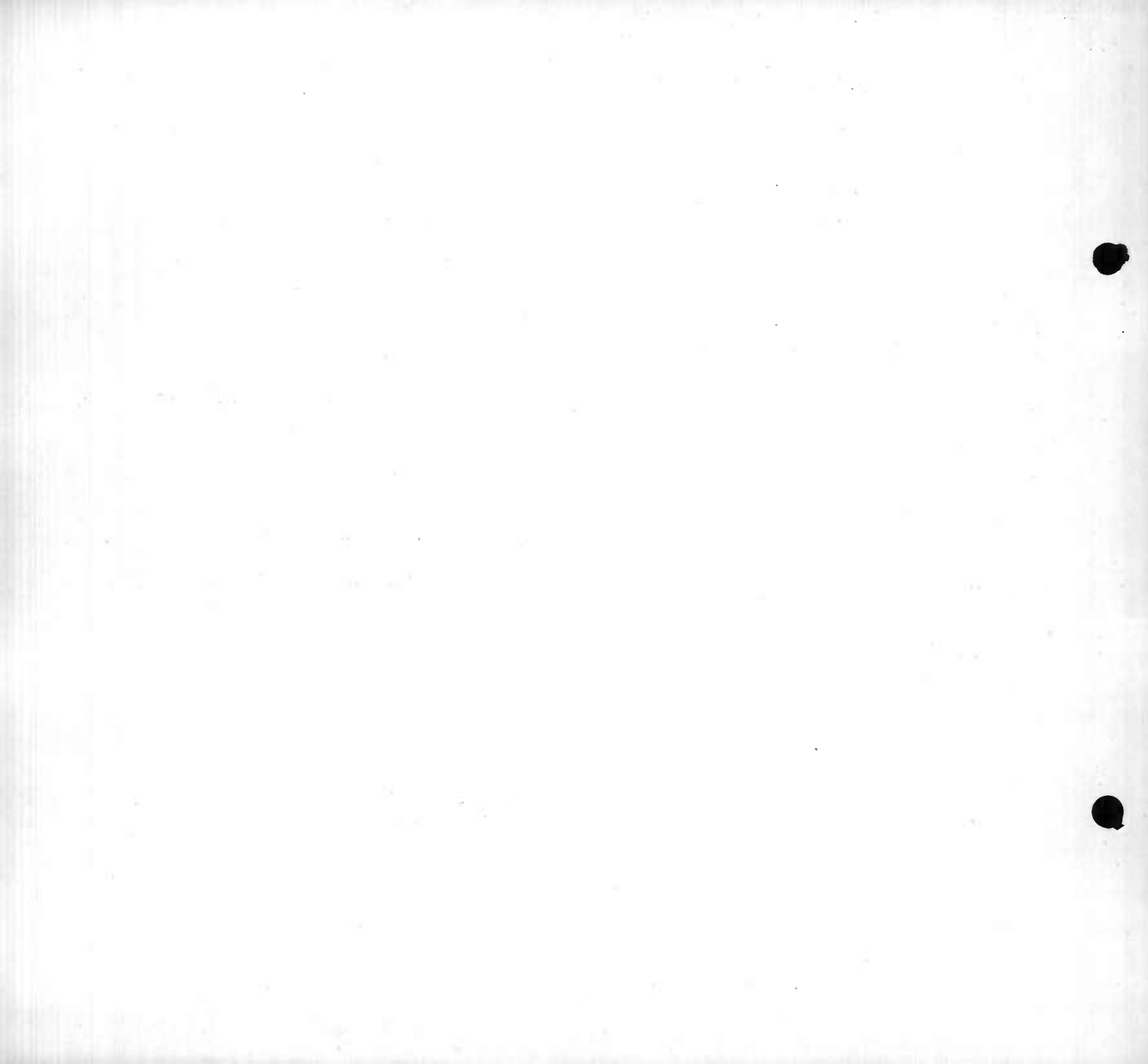
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>287</u>
69 6833		69 6833		5 ²² P M.
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Beulah Hort</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>7/5/69</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Horton View Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>anne arundel</u> <u>5200</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1213 Light St</u>		C. CITY OR TOWN <u>Glen Burnie Md</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>7</u> 6. RACE <u>C</u>		E. STREET AND NUMBER <u>Rt 1 B488</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 16, 1891</u> 9. AGE (In years lost birthday) <u>77</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Suite</u>		
14. MOTHER'S MAIDEN NAME <u>Susan Curtis</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>213-09-2015</u>		17. INFORMANT <u>daughter</u> ADDRESS <u>Rt. 1 B488 Glen Burnie Md</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>250.9 I</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral thrombosis</u> <u>6/1/69</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u> <u>yes</u>		
		(C) <u>arteriosclerosis</u> <u>yes</u>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> 19 <u>69</u> to <u>7/5</u> 19 <u>69</u> . that (I) (we) last saw the deceased alive on <u>7/5</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u> DEGREE				23B. DATE SIGNED <u>7/6/69</u>
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MAERTZ MD</u> DEGREE		23D. ADDRESS <u>2 E Pearl St Baltimore Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-9-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. (State) <u>Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, MD</u>		25C. FUNERAL DIRECTOR <u>Edgar S. Wilson</u> ADDRESS <u>1000 Brantley Ave.</u>



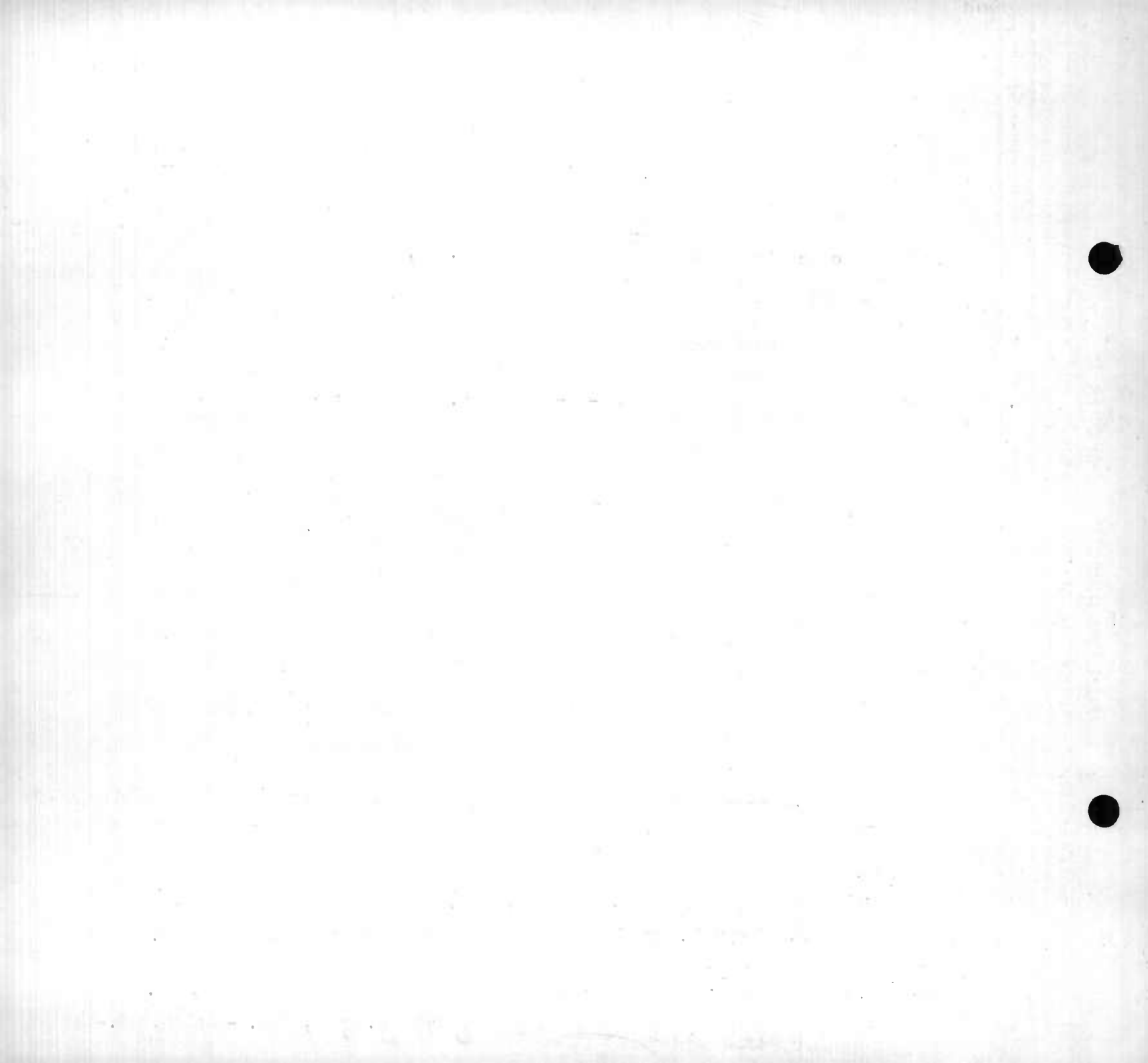
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 6834 CERTIFICATE OF DEATH

REG. NO.

69 6834

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ALFREDO GARRASI		July 6, 1969 9 ³⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines Belaire				A. STATE Maryland	
				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4016 Southern Avenue	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
male	caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 16, 1872	96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Laborer				Italy	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Vincent Garrasi			Tura ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-56-2494		Mrs. Vencenzina Garrasi	
				ADDRESS (Same)	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Acute Pneumonia</p> </div> <div style="width: 45%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>2 days</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Pulmonary Edema</p> </div> <div style="width: 45%;"> <p>2 days</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Arteriosclerotic Heart Disease</p> </div> <div style="width: 45%;"> <p>years</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p>Chronic Hypertension & Nephritis Arteriosclerosis</p> <p>Chronic Brain Syndrome Multiple Disabilities</p> </div> <div style="width: 45%;"> <p>Months</p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/8/1969 to 7/6/1969, that (I) (me) last saw the deceased alive on 7/6/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				7/7/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Albert B. Bradley				4900 Belair Road, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial Entombment		7/9/69.		Holy Redeemer Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1969		Robert E. Taylor, M.D.		Leonard J. Buck, Inc. - Balto, Md.	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6835	
BIRTH NO. 69 6835		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) REGINA E. NEUBERTH			2. DATE AND HOUR OF DEATH July 5, 1969 9:20 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3105 Taylor Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2735 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3105 Taylor Avenue		
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1885	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10B. KIND OF BUSINESS OR INDUSTRY Dept. store, Hutzler's		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Robert S. Toland		
14. MOTHER'S MAIDEN NAME Josephine E. Rastetter			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 215-10-6618A			17. INFORMANT ADDRESS Alice G. Neuberth, 3105 Taylor Ave.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 174 X I METASTATIC CARCINOMA OF LUNG CARCINOMA OF BREAST 6 MO 1 YR.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION O					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 69 to July 5 1969 , that (I) (we) last saw the deceased alive on May 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Marcio Menendez				23B. DATE SIGNED 7/5/69	
23C. PHYSICIAN'S NAME (Type) Dr. Marcio Menendez				23D. ADDRESS 6131 Marlora Road	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7-9-69		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Gable, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.-Baltimore, Md. -14	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6836	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) FRANCES CUSHEN</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 7/4/69 2:30 A.M.</p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1529 Lockwood Road</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2759</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1529 LOCKWOOD ROAD</p>		
<p>5. SEX FEMALE</p>	<p>6. RACE W</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 2/23/78</p>	<p>9. AGE (In years last birthday) 91</p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>			<p>11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>
<p>13. FATHER'S NAME WILLIAM SIMMONS</p>			<p>14. MOTHER'S MAIDEN NAME HARRIETTA PRICE</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>			<p>16. SOCIAL SECURITY NO. 216-46-7059</p>	<p>17. INFORMANT MRS. MAE C. MEYER ADDRESS 1529 LOCKWOOD RD.</p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A. S. O. D.</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> <p style="text-align: right;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 7ps.</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 1945 to 7/4/69, that (I) (we) last saw the deceased alive on 7/3/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <i>Walter Karfigin</i></p>				<p>23B. DATE SIGNED 7/6/69</p>	
<p>23C. PHYSICIAN'S NAME (Type) Walter Karfigin</p>				<p>23D. ADDRESS 4331 Harford Road Balto. Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7/7/69</p>	<p>24C. NAME OF CEMETERY or CREMATORY Lorraine Pk.</p>		<p>24D. LOCATION (City, town, or county) (State) Balto. Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT.</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher, M.D.</p>		<p>25C. FUNERAL DIRECTOR Leonard J. Fick Inc. Balto. Md. ADDRESS</p>	

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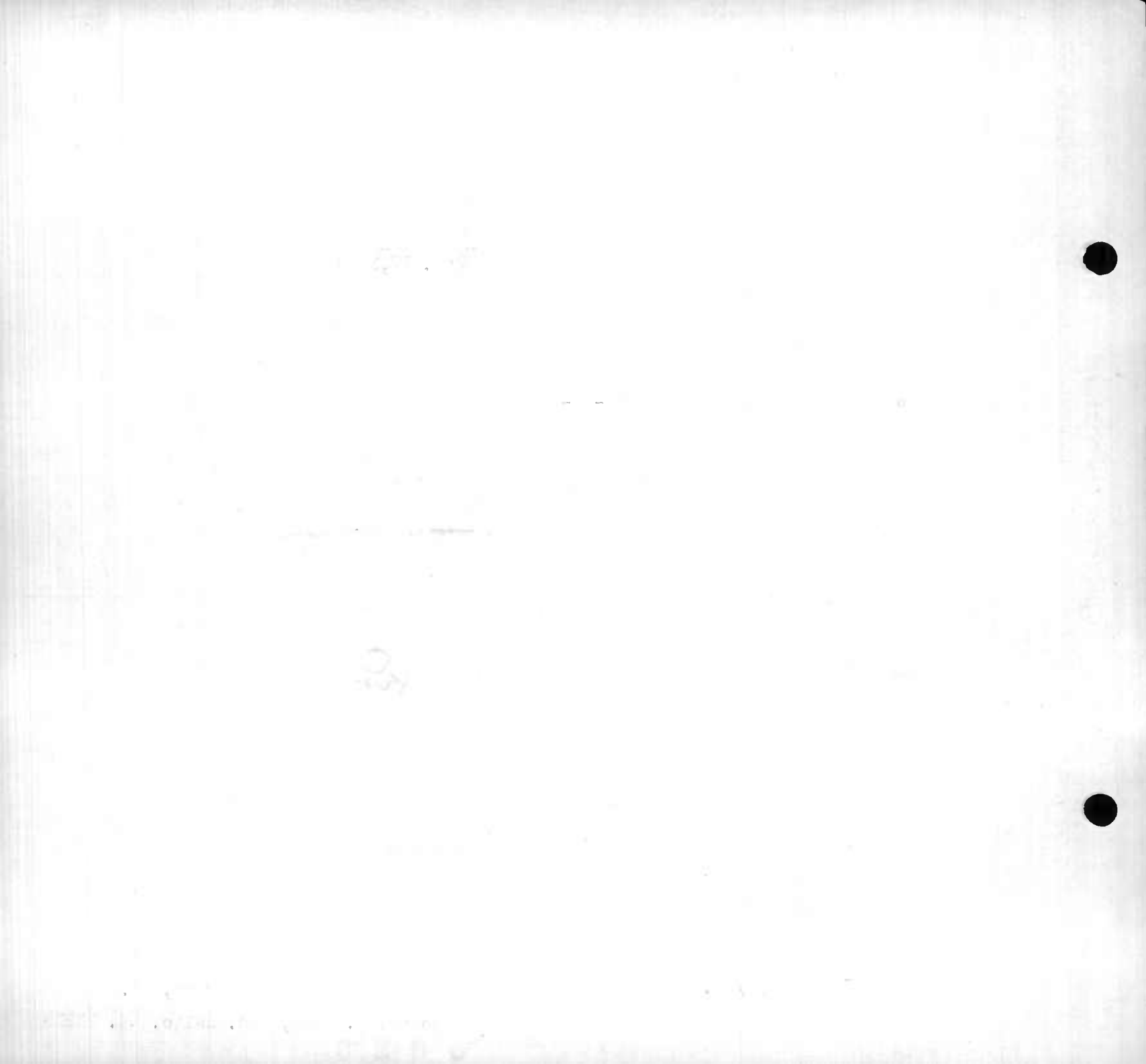
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6837	
69 6837				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WHITTEN, MARIE S.		July 4th, 1969 4:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			MARYLAND		
44 UNION MEMORIAL HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3116 LAWNVIEW AVENUE		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE		Jan. 17, 1892	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		None		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNKNOWN William Hess			unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-26-2284		WHITTEN, GEORGE W., Jr. 5807 WILLAMTON Ave.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			acute myocardial insufficiency		
			D. H.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 06-24-69 19 69 to July 4th 1969, that (I) (we) lost saw the deceased alive on July 4th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Cabrera M.D. DEGREE				7/4/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CABRERA, JUAN M. M.D. DEGREE				UNION MEMORIAL HOSPITAL.	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	7/8/69.	Baltimore Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 8 1969		Robert E. Fisher, M.D.		Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6838	
BIRTH NO. 69 6838		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William Henry Heinze		2. DATE AND HOUR OF DEATH July 4, 1969, 9 50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital 48		A. STATE Md		B. COUNTY 1701	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER Congress Hotel 206 W. Franklin St			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/89	9. AGE (in years last birthday) 29	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Painter-Decorator		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Heinze		14. MOTHER'S MAIDEN NAME Margaret Lacompe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown yes WWI		16. SOCIAL SECURITY NO. 218-01-6176		17. INFORMANT Ernest E. Heinze 3029 E. Northern Pkway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Pulmonary Edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Dehydration					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 19 69 to July 4 19 69 that (I) (we) last saw the deceased alive on July 4 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Hawkins MD		23B. DATE SIGNED 7/4/69			
23C. PHYSICIAN'S NAME (Type) Robert Hawkins M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. LOCATION (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Quack Inc. Balto. Md.	
25D. ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

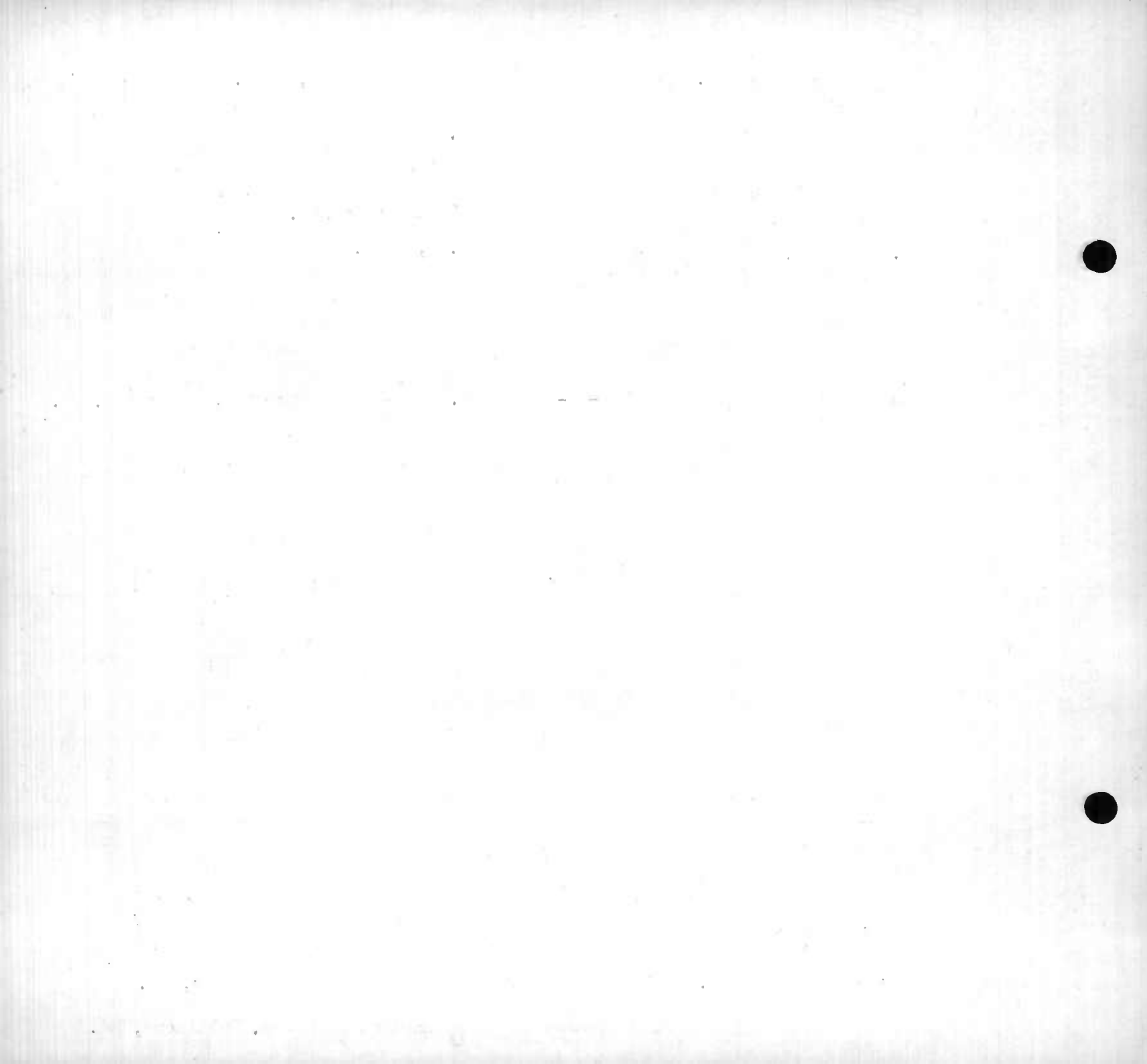
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6839</u>	
69 6839				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>KING, JULE G.</u>		2. DATE AND HOUR OF DEATH <u>3:10 AM 7/5/69</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2748</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1/17/90</u>		9. AGE (In years last birthday) <u>79</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JAMES S. KING</u>		14. MOTHER'S MAIDEN NAME <u>ANNA COTLER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 48 9443</u>		17. INFORMANT <u>Miss Ann Peters</u>	
18. <u>3-69-91</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gastrointestinal Bleeding</u>		<u>4 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>UNKNOWN</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Arteriosclerotic cardiovascular disease</u>		<u>10 years</u>	
19A. DATE OF OPERATION <u>0 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/30/1969</u> to <u>7/5/1969</u> that (I) (we) last saw the deceased alive on <u>7/4/1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Francis T. Daly M.D.</u>		23B. DATE SIGNED <u>7/5/69</u>		23C. PHYSICIAN'S NAME (Type) <u>FRANCIS T. DALY</u>	
23D. ADDRESS <u>3201 N. CHARLES ST.</u>		23E. DEGREE <u>M.D.</u>		23F. DEGREE <u>M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/69.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
24G. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md.</u>		24H. ADDRESS <u>Baltimore, Md.</u>		24I. ADDRESS <u>Baltimore, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
69 6840		CERTIFICATE OF DEATH		69 6840
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Frederick W. Bau		July 4, 1969. 10:20 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. 2733		
90 Gould Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3306 Batavia Ave.		
5. SEX M.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1882.	9. AGE (In years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Christian Bau		14. MOTHER'S MAIDEN NAME Emma Marquardt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-6457	17. INFORMANT Mrs. Katherine Hirschmann, 4023 Greenmount Ave. Balto. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, or as a consequence of: Acute pulmonary edema Chronic Myocarditis Arteriosclerotic C-V disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2+ hours 11 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from Feb 58 to July 4 1969, that (I) (we) last saw the deceased alive on July 4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE H.V. Harbold M.D.		23B. PHYSICIAN'S NAME (Type) H.V. HARBOLD M.D.		23C. ADDRESS 4706 Harford Road Baltimore Md
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery
				24D. LOCATION Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Gaben, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						69 6841		REG. NO. 69 6841	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wiles, William Edward</i>				2. DATE AND HOUR OF DEATH <i>7/5/69 4:45 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hosp</i>						A. STATE <i>Md.</i>		B. COUNTY <i>2748</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>5509 Leith Rd.</i>									
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/29/17</i>		9. AGE (In years last birthday) <i>51</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>baker helper</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>? Louis E. Wiles</i>				14. MOTHER'S MAIDEN NAME <i>? Grace M. Sherman</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>213-01-695</i>		17. INFORMANT <i>Gladys Dix</i>		ADDRESS <i>5509 Leith Rd.</i>	
18. <i>593.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac decompensation</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>renal failure</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>diabetes and/or obstruction</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>?</i>					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>5/14</i> 19 <i>69</i> to <i>7/5</i> 19 <i>69</i> , that (I) <u>(we)</u> last saw the deceased alive on <i>7/5</i> 19 <i>69</i> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.									
23A. SIGNATURE <i>Robert W. Ireland</i>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/5/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland M.D.</i>						23D. ADDRESS <i>Montebello State Hosp 2201 Argonne Dr</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/9/69</i>		24C. NAME of CEMETERY or CREMATORY <i>Good Shepherd Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Ellicott City, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1969</i>				25B. NAME OF REGISTRAR <i>Robert W. Ireland, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc. Balto. Md.</i>			

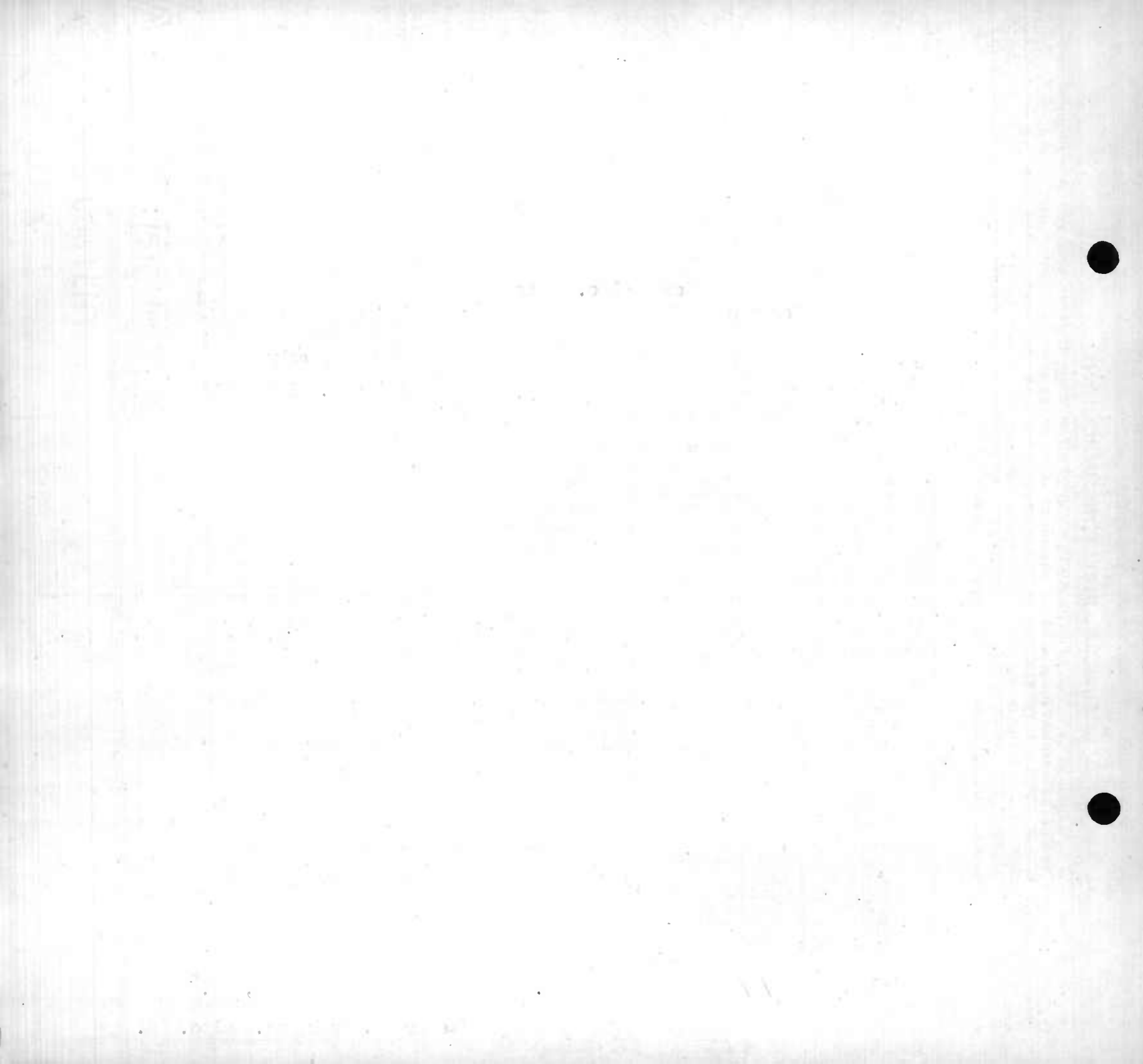
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

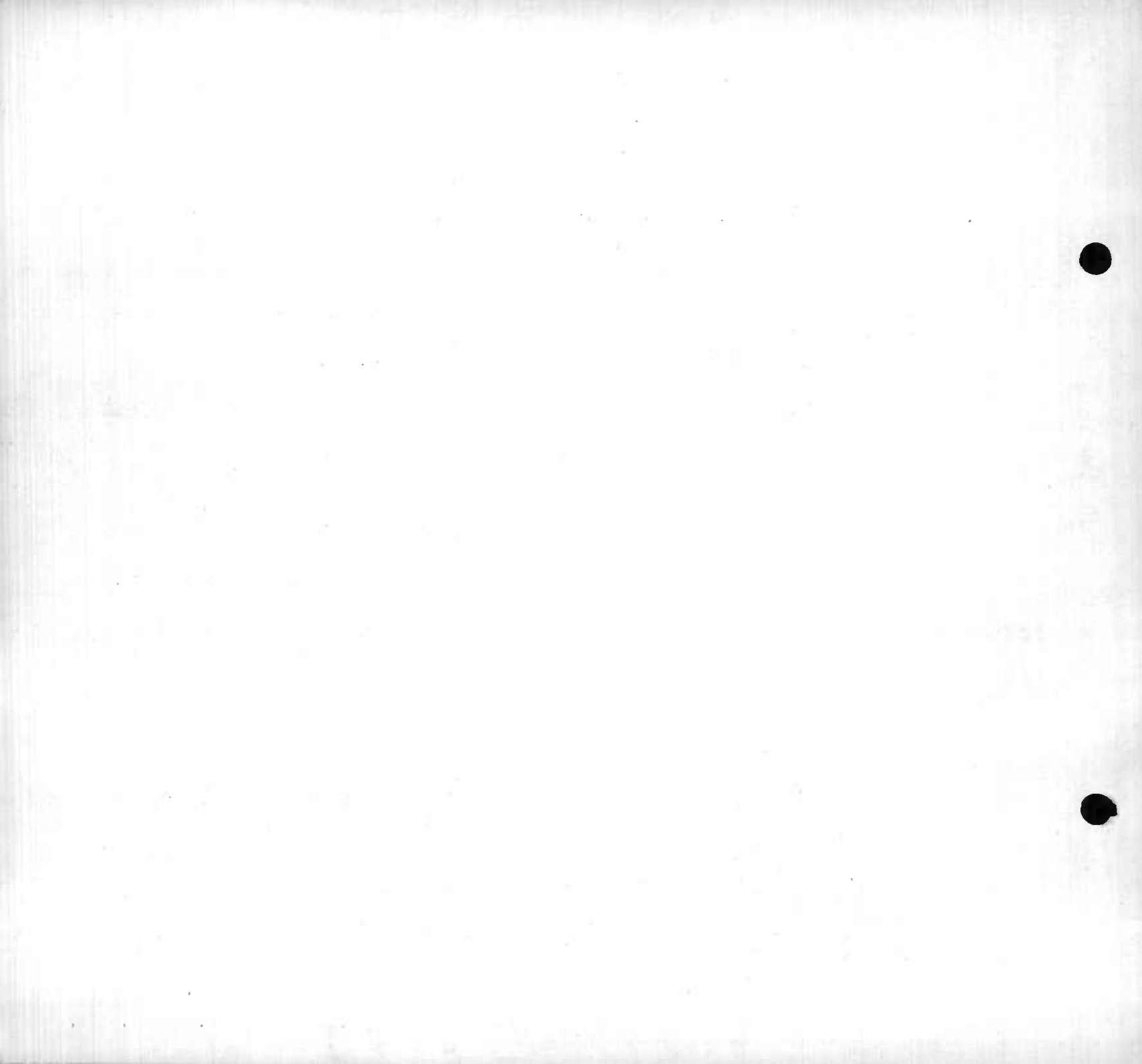
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
69 6842		69 6842		69 6842
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
FITZGERALD JAMES John		July 5, 1969 12 ²⁰ P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
45 GOOD SAMARITAN HOSPITAL		MARYLAND 2758		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		2043 RAMBLEWOOD ROAD		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
M	CAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-21-13	56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
PRINTER Foreman		Lord Balto. Press		BALTIMORE MARYLAND
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
JAMES THOMAS FITZGERALD		ANNA - Rosky		U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
<input checked="" type="checkbox"/> W. W. II		215-09-6307		Thelma E. Fitzgerald
				WIFE ABOVE
18. 712.31		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		10 YEARS
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Rheumatoid Arthritis		
DUE TO, OR AS A CONSEQUENCE OF:		(B) Cere		
DUE TO, OR AS A CONSEQUENCE OF:		(C)		
DUE TO, OR AS A CONSEQUENCE OF:		(D)		
DUE TO, OR AS A CONSEQUENCE OF:		(E)		
DUE TO, OR AS A CONSEQUENCE OF:		(F)		
DUE TO, OR AS A CONSEQUENCE OF:		(G)		
DUE TO, OR AS A CONSEQUENCE OF:		(H)		
DUE TO, OR AS A CONSEQUENCE OF:		(I)		
DUE TO, OR AS A CONSEQUENCE OF:		(J)		
DUE TO, OR AS A CONSEQUENCE OF:		(K)		
DUE TO, OR AS A CONSEQUENCE OF:		(L)		
DUE TO, OR AS A CONSEQUENCE OF:		(M)		
DUE TO, OR AS A CONSEQUENCE OF:		(N)		
DUE TO, OR AS A CONSEQUENCE OF:		(O)		
DUE TO, OR AS A CONSEQUENCE OF:		(P)		
DUE TO, OR AS A CONSEQUENCE OF:		(Q)		
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>2116</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Lillian M. Kaiser</u>		2. DATE AND HOUR OF DEATH <u>July 4, 1969</u> <u>5</u> <u>17</u> ⁸⁰ ^{PM}		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Harbor View Nursing Home</u> <u>1218 Light St., Balt., Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>908 Woodson Rd. 21212</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/31/1873</u>	9. AGE (In years lost birthday) <u>95</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY 		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Isaac Miller</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>29-45-5961</u>		
17. INFORMANT <u>Mrs Butler</u>		ADDRESS <u>908 Woodson Rd</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral thrombosis</u> (B) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u> (C) <u>arteriosclerosis</u> , <u>gen</u> <u>years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>6/2/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> <u>1969</u> to <u>7/4</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>7/4</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date <u>7/4</u> <u>1969</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>ALLAN H. MACHT MD</u>				23B. DATE SIGNED <u>7/5/69</u>
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>				23D. ADDRESS <u>2 E. READ ST BALTIMORE 21212</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/7/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenwood Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <u>CATHERINE MILLER</u>		2. DATE AND HOUR OF DEATH <u>July 5, 1969</u> <u>12 midnight</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO. CO.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME & HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1214 BERTWOOD RD.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-89</u>	9. AGE (In years last birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>EDWARD POLAND</u>		
14. MOTHER'S MAIDEN NAME <u>MARY McGRADY</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>217-50-1891</u>		17. INFORMANT <u>RAYMOND MILLER</u>		
18. <u>200.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ACUTE PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>LYMPHOSARCOMA & MULTIPLE METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>5-18-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>LYMPHOSARCOMA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>April 24</u> 19 <u>69</u> to <u>July 5</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>July 5</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Corazon Z. Vergara, M.D.</u>				23B. DATE SIGNED <u>July 6, 1969</u>
23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>				23D. ADDRESS <u>Church Home & Hospital 100 N. Broadway Baltimore, Md. 31</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>7/6/69</u>		24C. NAME of CEMETERY or CREMATORY <u>CALVARY CEM</u>
24D. LOCATION <u>PITTS PA.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		
25B. NAME OF REGISTRAR <u>John E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>John E. Taylor M.D.</u>		
25D. ADDRESS <u>4900 Centre Drive, Pitts. Pa.</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

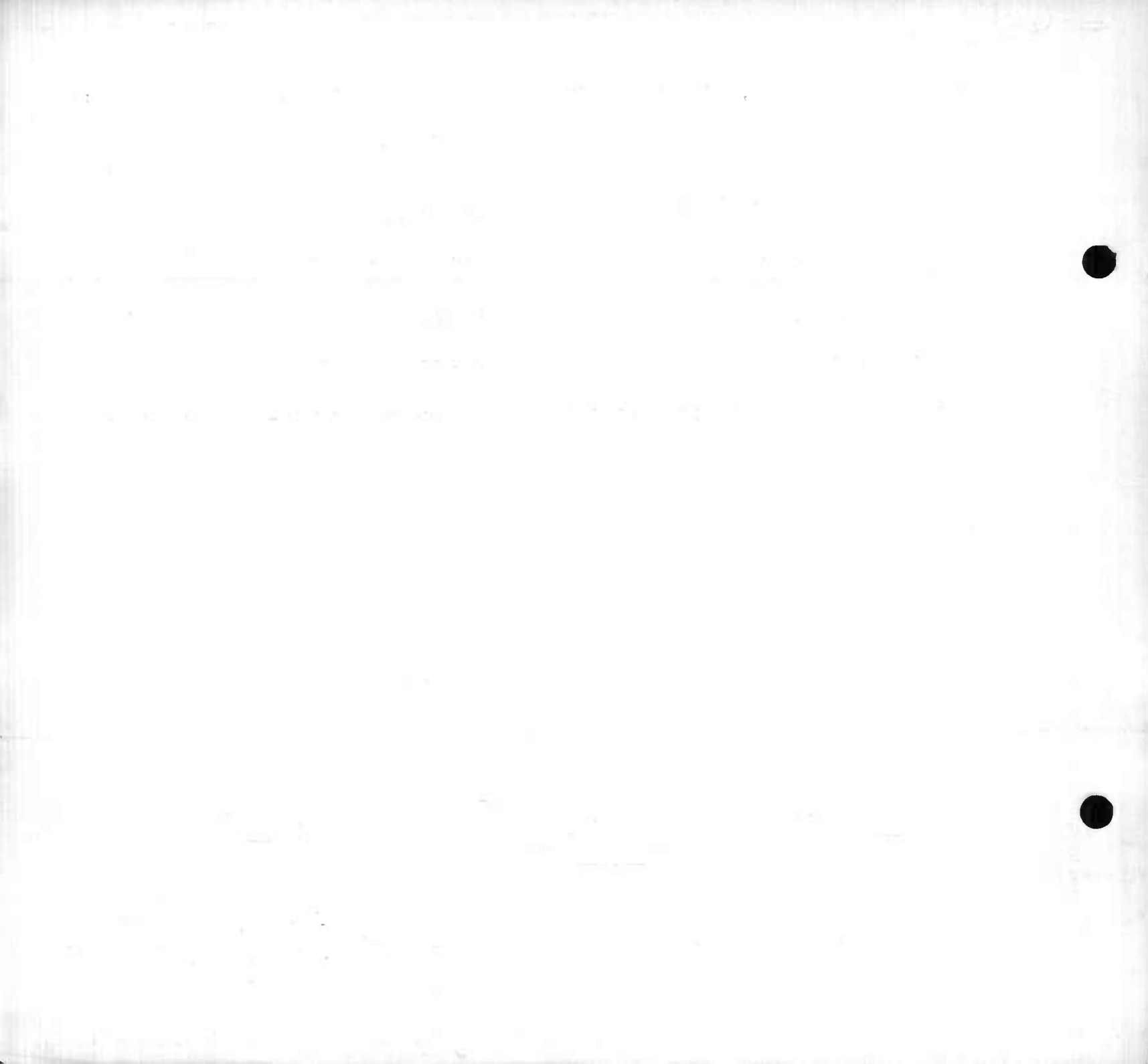
69 6845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 6845

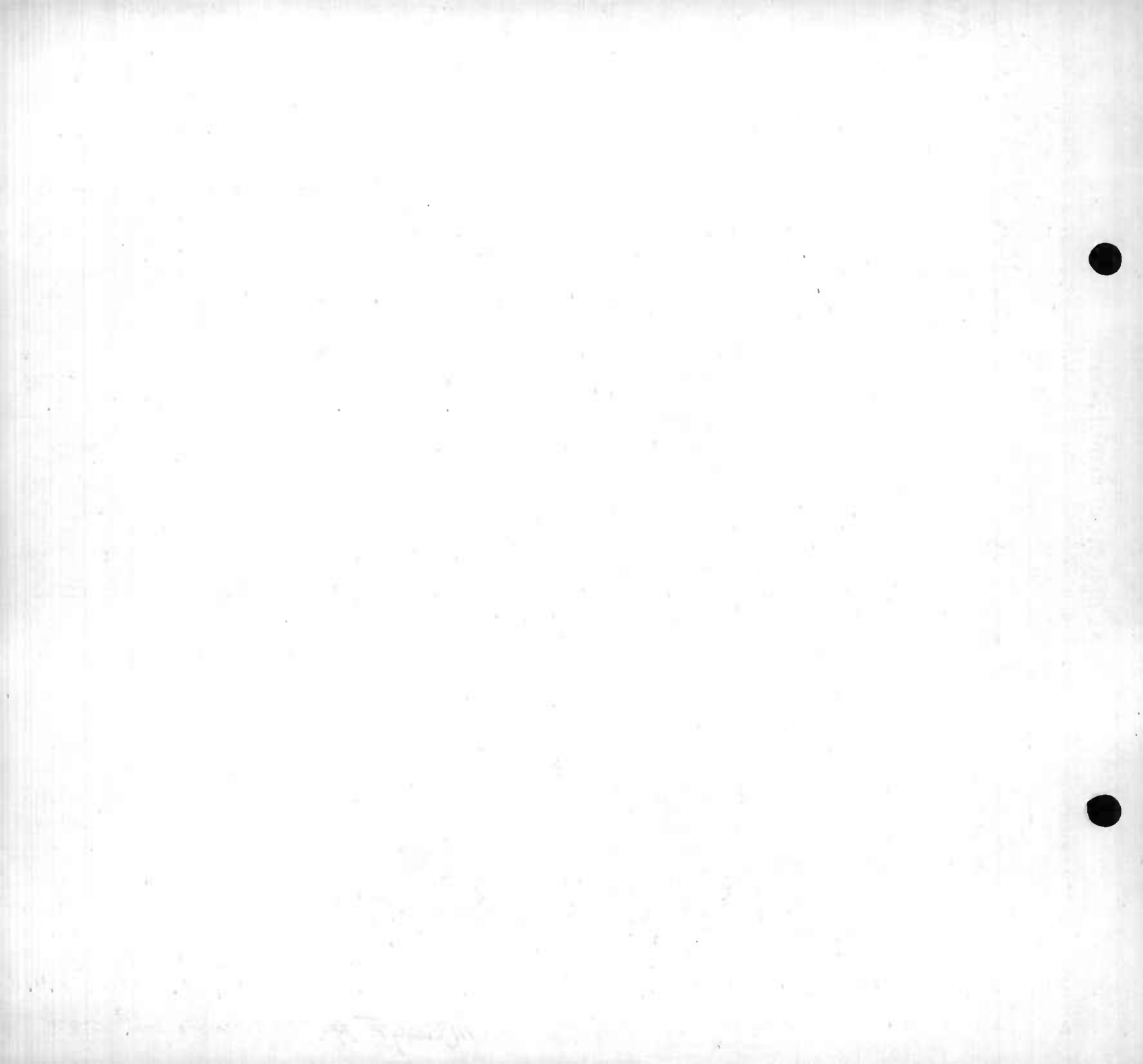
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GRANT, WALTER ELWOOD		JULY 2, 1969 9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
40 ST AGNES HOSPITAL				MARYLAND Balto. Co. 5300	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				928 KENT AVENUE	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	04 03 23	46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PIPE FITTER		CONSTRUCTION		MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
WALTER GRANT			U S A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
YES WORLD WAR 11			217184217		ST AGNES RECORDS-CATON & WILKINS AVE
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At <input type="checkbox"/> Not While At <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from JUNE 26 1969 to JULY 2 19 69 that (X) (we) last saw the deceased alive on JULY 2 19 69 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
ADOLFO ALONSO				07 02 69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				BALTO, MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-7-69		Baltimore National	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 8 1969		E. Taylor, M.D.		Taylor - Caton & Wilkins, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 1636 24 6846			
1. NAME OF DECEASED (Type or Print) SCHEIBE, CARROLL THOMAS				2. DATE AND HOUR OF DEATH 7/6/69 6:55 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital 43				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland B. COUNTY Anne Arundel 5200			
5. SEX M				6. RACE W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10/30/06				9. AGE (In years last birthday) 62			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10B. KIND OF BUSINESS OR INDUSTRY Baltimore Police Dept				11. BIRTHPLACE (State or foreign country) MD (Somerset Co)			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Scheibe				14. MOTHER'S MAIDEN NAME Texena Landon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS 21225 Mrs. Thelma A. Scheibe 5718 Phillips St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Cancer				14 days			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: Cancer of Pancreas							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Pulmonary embolism?							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/23/1969 to 7/6/1969.				that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thant G. Lander, M.D.				23B. DATE SIGNED 7/6/69							
23C. PHYSICIAN'S NAME (Type) NIKANT RAJADANURAKS, M.D.				23D. ADDRESS South Balto. Gen. Hosp.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/10/69				24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park			
24D. LOCATION (City, town, or county) Glen Burnie, Md.				24E. ADDRESS 21061 A.A. C							
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969				25B. NAME OF REGISTRAR Robert E. Jaber, M.D.				25C. FUNERAL DIRECTOR ADDRESS 237 Patapsco Ave. 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO.		69 6847		69 6847	
1. NAME OF DECEASED (Type or Print) <i>Deal Miss Edna</i>			2. DATE AND HOUR OF DEATH <i>7.3.69</i> <i>5.45 P.</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home & Hospital</i> <i>100 N Broad Way Balt MD.</i>			A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> <i>831</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Female</i>			6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4.25.08</i>			9. AGE (In years last birthday) <i>61</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>OLC.</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Harry Deal</i>		
14. MOTHER'S MAIDEN NAME <i>Anna Foseh</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO.</i>		
16. SOCIAL SECURITY NO. <i>216-03-9912</i>			17. INFORMANT <i>Harry Deal</i> ADDRESS <i>same as he.</i>		
18. <i>571.91</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>embolic liver, bilateral pneumonia</i>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CHF paralytic ileus.</i>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6.10.1967</i> to <i>7.3.1969</i> that (I) (we) last saw the deceased alive on <i>7.3.1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cezar A. Lopez MD</i>				23B. DATE SIGNED <i>7.3.69</i>	
23C. PHYSICIAN'S NAME (Type) <i>CEZAR A. LOPEZ MD</i>				23D. ADDRESS <i>CHURCH HOME AND HOSP.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7/7/69</i>		24C. NAME of CEMETERY or CREMATORY <i>MORELAND MEMORIAL PARK</i>	
24D. LOCATION (City, town, or county) (State) <i>PARKVILLE MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1969</i>			
25B. NAME OF REGISTRAR <i>James E. Talbot MD.</i>		25C. FUNERAL DIRECTOR <i>VALERIE'S FUNERAL HOME 4210 BELAIR</i>			
25D. ADDRESS					



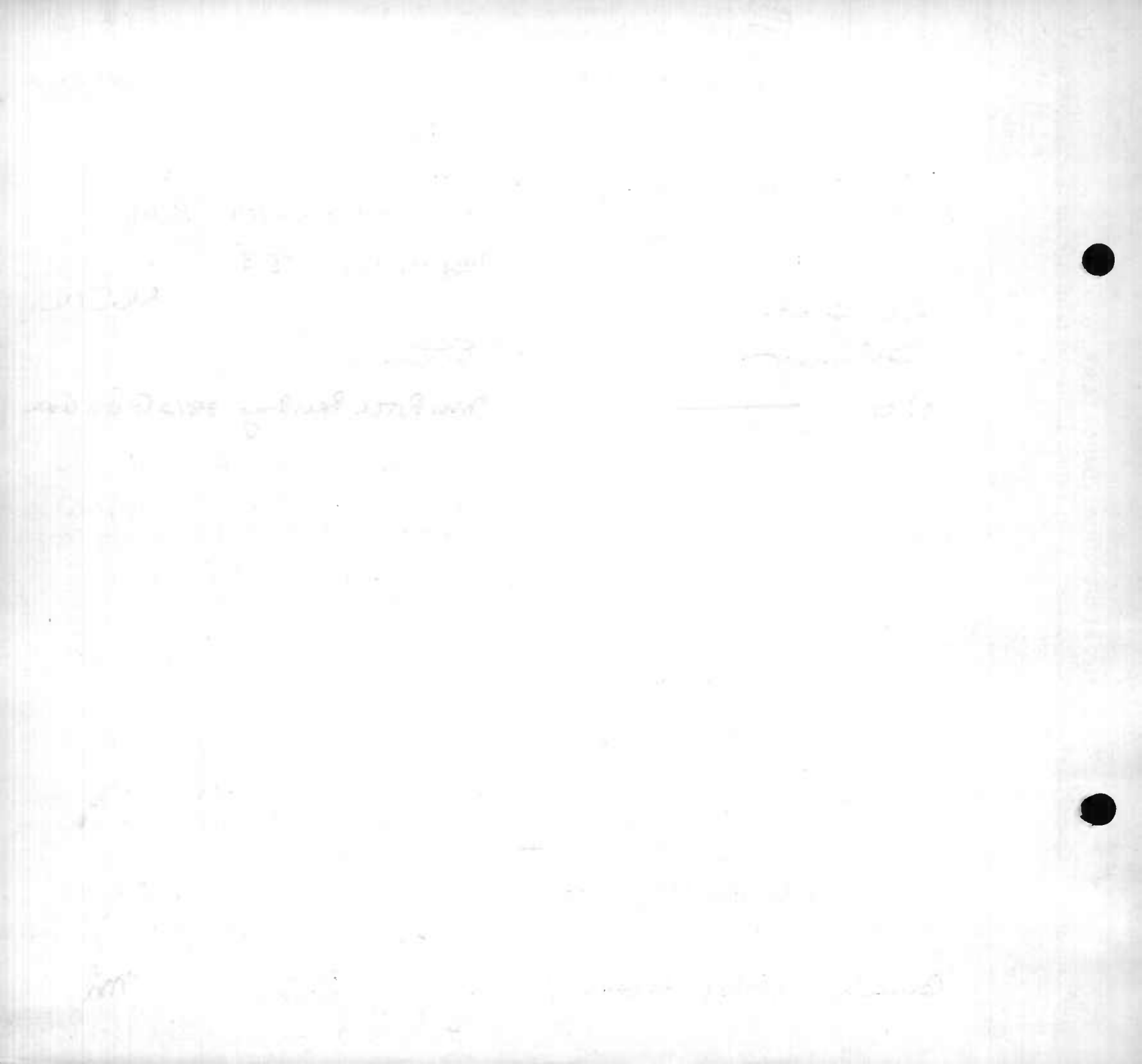
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6848 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 6848

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SHAPIRO, Celia		2. DATE AND HOUR OF DEATH 7-3-69 4:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1510		
FULL NAME OF HOSPITAL OR INSTITUTION JEWISH CONVALESCENT & NURSING HOME			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 4101 BARRINGTON ROAD		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1881	9. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wing guards		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LATVIA	
13. FATHER'S NAME Solomon			14. MOTHER'S MAIDEN NAME Etta		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-1389A		17. INFORMANT Mrs Ruth Reimberg	
				ADDRESS 3812 Glen Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/23/154.1			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Heart Dis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus Post op. status Ca of Rectum		6 years
			(C) Anemia, mild.		11 years
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1958		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Rectum		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1935 19 to 7/3 19 69 , that (I) (we) last saw the deceased alive on 7/2/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sol Smith M.D.				23B. DATE SIGNED 7/3/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 3802 W. Rogers Ave Baltimore Md 21215	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/4/69		24C. NAME of CEMETERY or CREMATORY Anshe Nezer	
24D. LOCATION (City, town, or county) (State) Balta Md		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR William S. Lewis	
		25C. FUNERAL DIRECTOR William S. Lewis		ADDRESS 2509 96th Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6849
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SALLY GRIEBLER		July 6/69 7:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinner Hoop			A. STATE Md B. COUNTY 2719		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5714 Jorgueil Ave		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 12, 1914	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel		14. MOTHER'S MAIDEN NAME Rose		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sally Griebler	
18. 25091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DARK MYOCARDIAL INFARCTION (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 59 to 7/6/69, that (I) (we) last saw the deceased alive on 7/6/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Metrom B. Kinsler				23B. DATE SIGNED 7/6/69	
23C. PHYSICIAN'S NAME (Type) Metrom B. Kinsler				23D. ADDRESS DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY or CREMATORY Rodeo Zedack	
24D. LOCATION Balto		24E. STATE Md		24F. CITY OR TOWN Balto	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR James E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc	
25D. ADDRESS 9610 Reisterstown Rd					

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Handwritten notes in the top right corner, including the word "Handwritten" and other illegible text.

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Handwritten notes at the bottom of the page, including the word "Handwritten" and other illegible text.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68 6850</u>	
<div style="display: flex; justify-content: space-between;"> 69 6850 <u>Reinhold C. Schreier</u> CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Schreier - Reinhold C.</u>			
2. DATE AND HOUR OF DEATH <u>4:30 A.M. 7-3-1969</u>		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2757</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Maryland University Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>2914 GLEDALE AVE.</u>					
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-11</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC, Sheet Metal Electrical</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>KURT - Schreier</u>		14. MOTHER'S MAIDEN NAME <u>Dore</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 015084</u>		17. INFORMANT <u>Hazel R. Schreier</u>	
ADDRESS <u>SAM</u>					
18. <u>39591</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial failure</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Post aortic valve replacement</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6-26-1969</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Aortic Valve disease</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-22-69</u> 19 to <u>7-3</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>7-3</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rostan Fardin M.D.</u>		23B. DATE SIGNED <u>7-3-69</u>			
23C. PHYSICIAN'S NAME (Type) <u>ROSTAN FARDIN</u>		23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		25B. NAME OF REGISTRAR <u>James E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Budget Funeral Home Baltimore</u>	
ADDRESS <u>By New [unclear]</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6851
BIRTH NO. 69 6851		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Creighton, Sophronia</u>		2. DATE AND HOUR OF DEATH <u>July 3, 1969</u> <u>3:25</u> <u>P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> - "KESWICK" <u>1307</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>700 W 40th Street</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1888</u>	9. AGE (In years last birthday) <u>81</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady, O'Neil & Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W. Creighton</u>		
14. MOTHER'S MAIDEN NAME <u>Blackely, Sophronia</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-10-4222</u>		17. INFORMANT <u>Dwight R. H. Keswick</u>		
18. CAUSE OF DEATH <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cerebro-vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ischemic Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>1966</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10 April</u> <u>1968</u> to <u>3 July</u> <u>1969</u> , that (I) (we) last saw the deceased alive on <u>3 July</u> <u>1969</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Aubrey D. Richardson, M.D.</u>				23B. DATE SIGNED <u>3 July 1969</u>
23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson, M.D.</u>				23D. ADDRESS <u>700 W. 40th Street</u>
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>7-5-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>
24D. LOCATION <u>Baltimore Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		
25A. NAME OF REGISTRAR <u>Robert E. Talley</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley</u>		
25C. FUNERAL DIRECTOR <u>Robert E. Talley</u>		25D. ADDRESS <u>64 North W. Avenue</u>		

Weswick

James White

George W. Carpenter

1st Street

18

W. A.

W. A. White

Blackley

W. A. White

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANKLIN PROBST		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 4, 1969	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1969 7:00 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Ft. Meade	
9. DATE OF BIRTH 22 Sept 92		10. AGE (In years last birthday) 76	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Coal Mine	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no or unknown) (If yes, give war or dates of service) Yes Navy		17. SOCIAL SECURITY NO. 165051524	
13. FATHER'S NAME Peter Probst		15. MOTHER'S MAIDEN NAME Mary Peters	
18. INFORMANT Raymond Decker Wilkibarre Pa		ADDRESS 7226 "D" Hall Street	
19. 41241		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7-8-69	
24C. NAME OF CEMETERY or CREMATORY Maple Hill Crematory		24D. LOCATION (City, town, or county) (State) Wilks Barre Pa	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Zuber, M.D.	
25C. FUNERAL DIRECTOR Burpee Funeral Home		ADDRESS Baltimore Md	

AMERICAN COLLEGE OF BUSINESS

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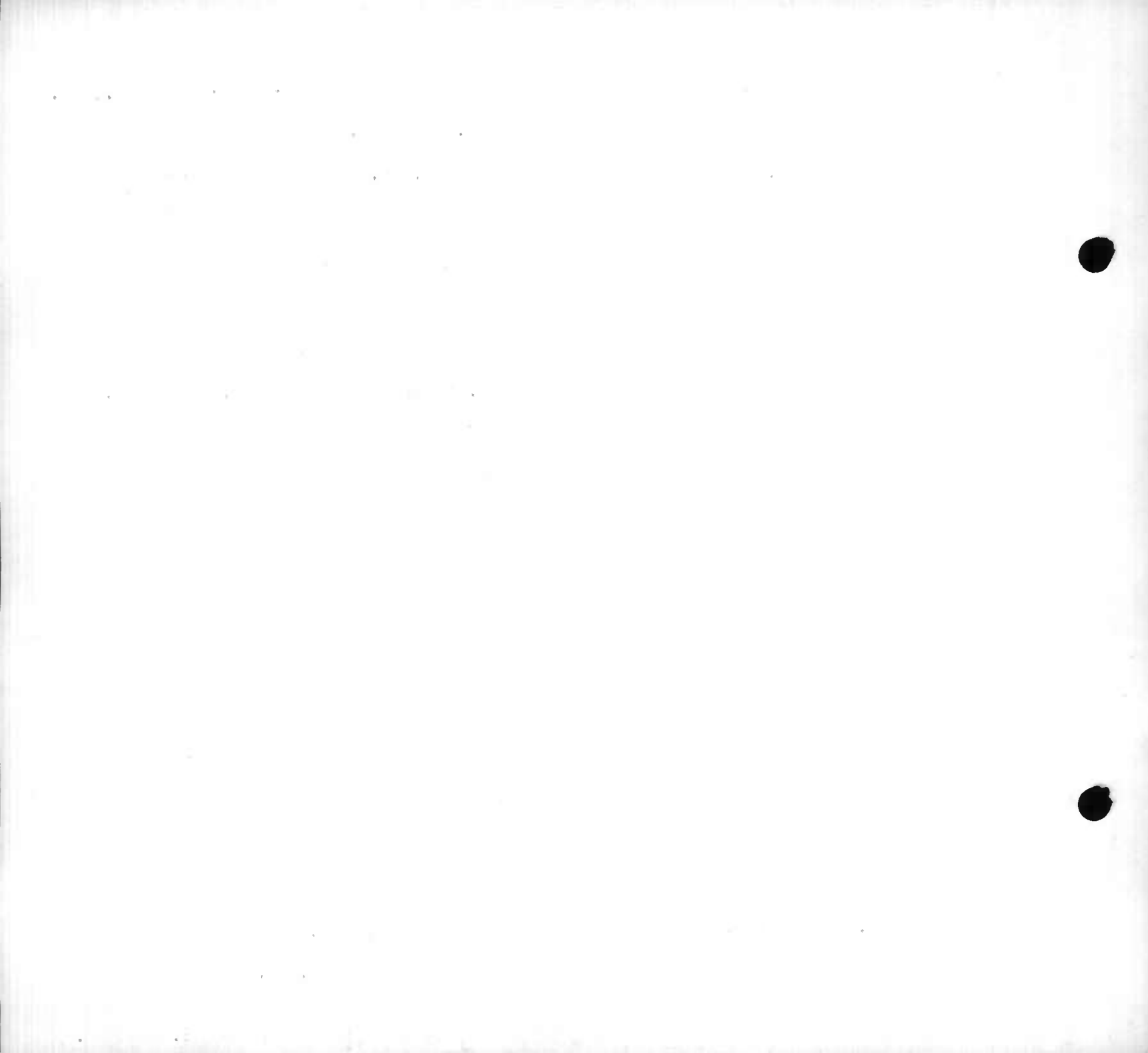
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6853	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BERARDO GABRIELE		2. DATE AND HOUR OF DEATH JULY 5th. 1969. 12.30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO.		C. CITY OR TOWN BALTO. Md.	
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOS.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 209 S. Exeter St.	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH I/30/1885	9. AGE (in years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? ITALY		13. FATHER'S NAME BENJAMEN GABRIELE		14. MOTHER'S MAIDEN NAME VIRGINIA DI DOMENICUS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, name unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. AMEDIO GABRIELE 209 S. EXETER ST.	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertension cardiac - Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I [A].		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 66 to 7/5 19 69 that (I) was lost saw the deceased alive on 6/30 19 69 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.					
23A. SIGNATURE DR. JOSEPH LIBERTO		23B. DATE SIGNED 7/7/69		23C. PHYSICIAN'S NAME (Type) DR. JOSEPH LIBERTO	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/68		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	
24D. LOCATION (City, town, or county) (State) BALTO. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Wm. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Frank V. [unclear]		25D. ADDRESS 322 S. HIGH ST.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6854 CERTIFICATE OF DEATH

REG. NO.

69 6854

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Huie Curvin (Hugh) (Huegh)

2. DATE AND HOUR OF DEATH

July 7, 1969

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

286 Mason Court

5. SEX

Male

6. RACE

Colored

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

12-25-1892

9. AGE (In years
lost birthday)

lost 78

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Loborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Darlington, S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lamart Kurvin, S.C.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.CHRONIC Cardio VASCULAR
DISEASE
CORONARY HEART DISEASE
CORONARY INSUFFICIENCYAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____
that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE



DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-12-69

24C. NAME OF CEMETERY or CREMATORY

North Side Cemetery

24D. LOCATION

(City, town, or county)

(State)

Fayetteville, North Carolina

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1969

25B. NAME OF REGISTRAR

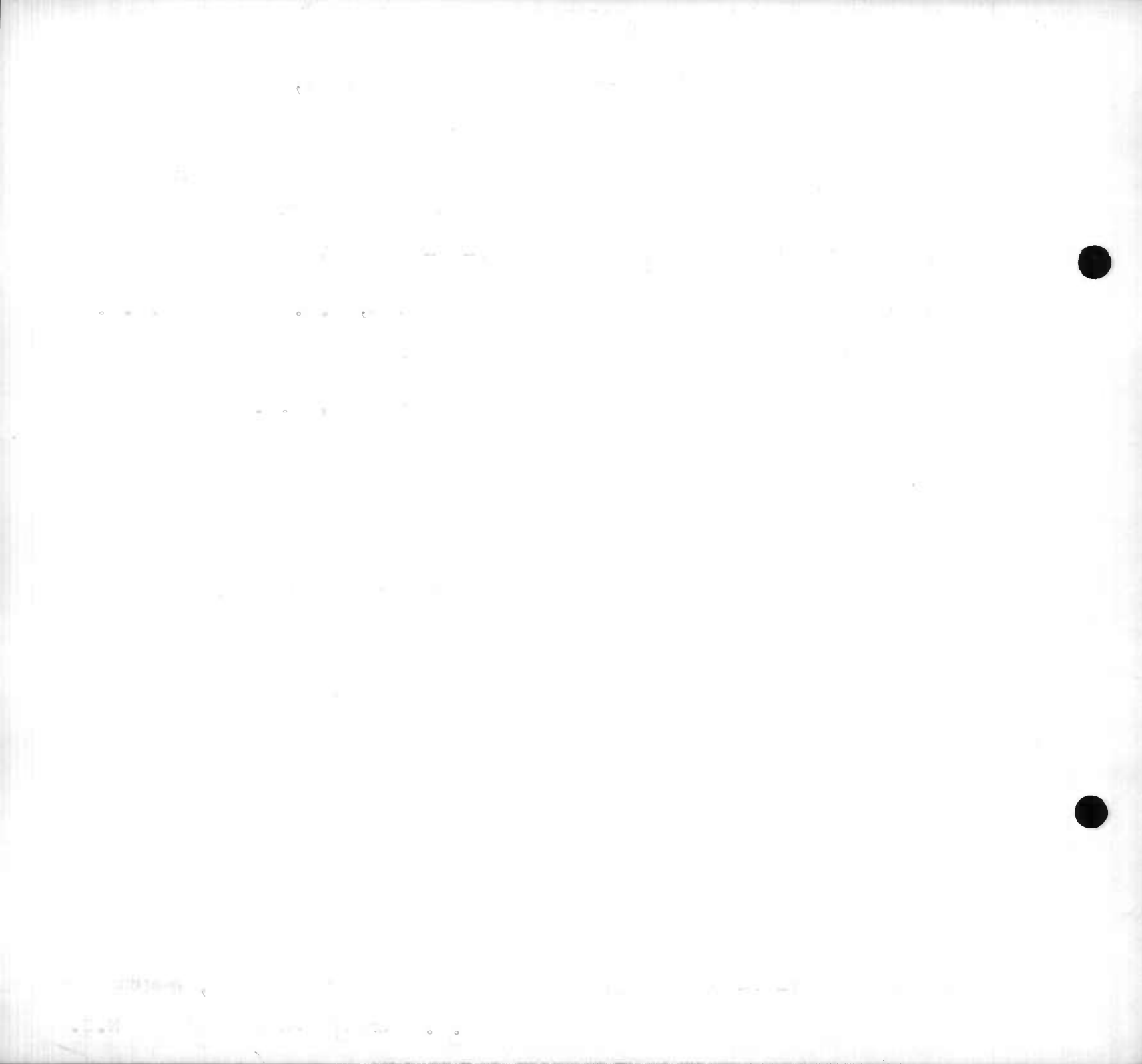
L. E. Garrison, M.D.

25C. FUNERAL DIRECTOR

L. E. Garrison

ADDRESS

Funeral Home N.C.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6855				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6855	
1. NAME OF DECEASED (Type or Print) Greene, Ida S.				2. DATE AND HOUR OF DEATH July 6th, 1969 5-30 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Harford			
5. SEX Female 6. RACE Colored 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN Forest Hill INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				E. STREET AND NUMBER 1501 E. Dukeland St.			
10B. KIND OF BUSINESS OR INDUSTRY Home				9. AGE (In years lost birthday) 85 yr.			
13. FATHER'S NAME Aquilla Harris				12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-54-2351			
17. INFORMANT J. Aquilla Greene				ADDRESS Box 666 Cooptown Road Forest Hill, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fracture of hip				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atrial fibrillation. One month (B) DUE TO, OR AS A CONSEQUENCE OF: Atrial fibrillation Arrhythmia (C) Fracture of hip			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 4-14-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Lt. leg.		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing home.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1501 E. Dukeland St.		21F. HOW DID INJURY OCCUR? By accidental fall.	
21D. TIME OF INJURY (APPROX.) 3 13 '69		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3-13-69 to 7-6-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kantilal J. Shah M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 6, 1969.	
23C. PHYSICIAN'S NAME (Type) Kan DR. Elroy Young M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/1969		24C. NAME OF CEMETERY or CREMATORY Fairview A.M.E.		24D. LOCATION (City, town, or county) (State) Forest Hill, Harford, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Charles E. Kurtz		25C. FUNERAL DIRECTOR ADDRESS 21084 Jarrettsville, Md.			

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. The second part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

3. The third part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

4. The fourth part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

5. The fifth part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

6. The sixth part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

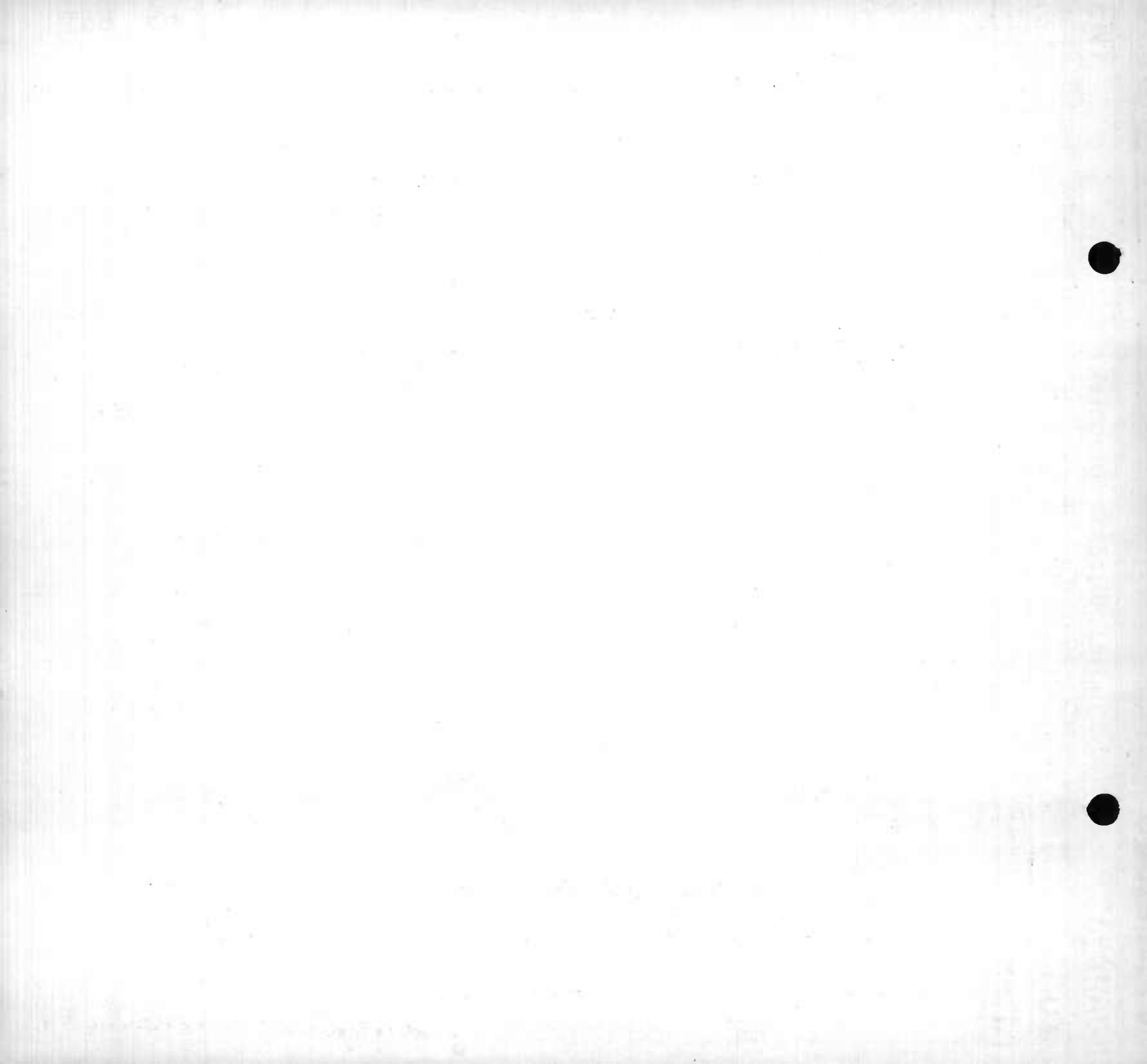
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 6856 CERTIFICATE OF DEATH

REG. NO. 2691 6856

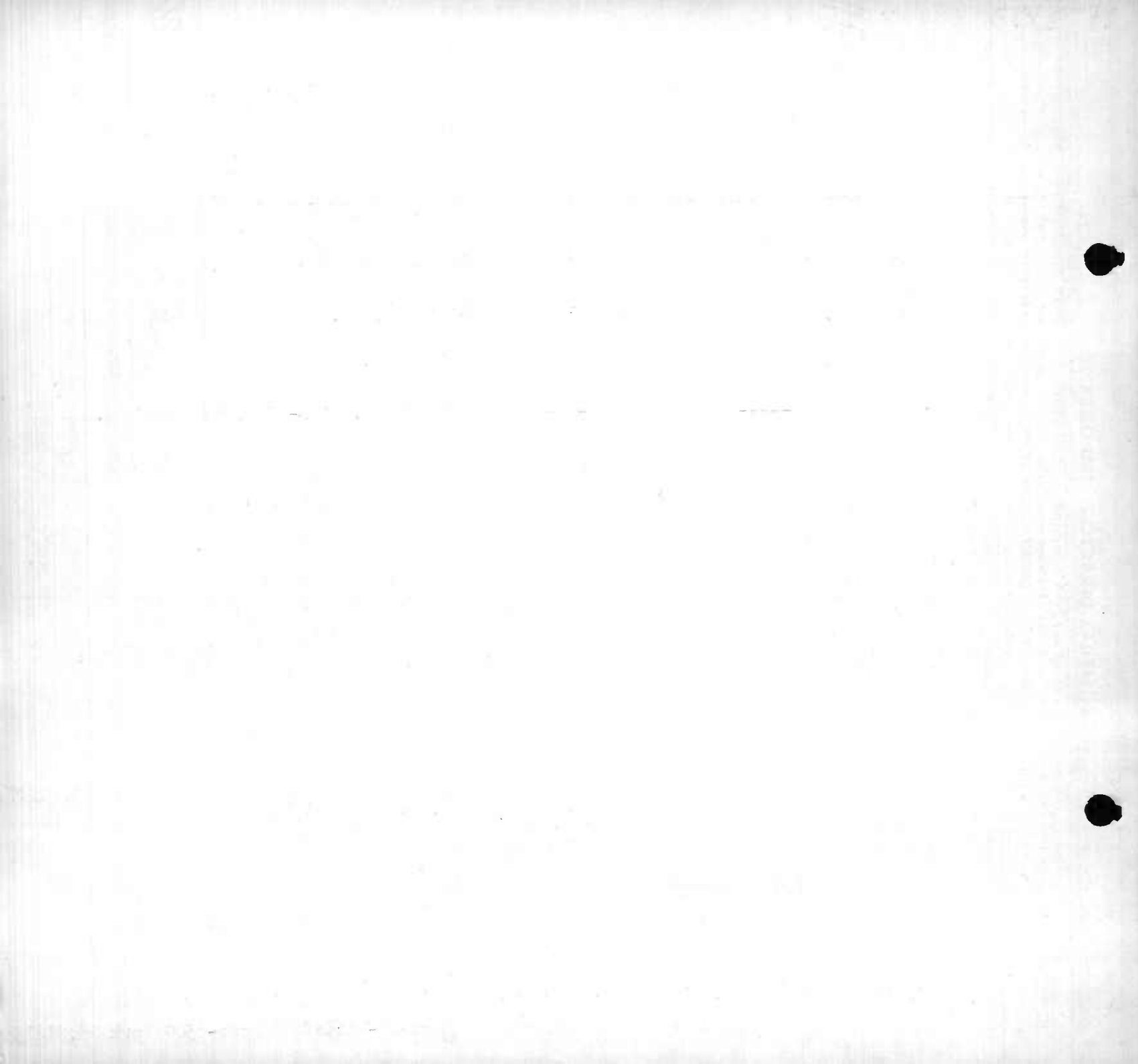
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRIEDA GUNKLE GUNKEL		2. DATE AND HOUR OF DEATH 7/1/69 - 5:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2744	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARBOR VIEW NURSING CENTER 90213 Light St. BALTO. MD-21230				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6136 FARDELAVE	
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/1885	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHN KASPER Eggert		14. MOTHER'S MAIDEN NAME KATELINA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-3807B		17. INFORMANT Wm. G. GUNKLE ADDRESS 1429 Maryland Rd. BALTO. MD	
18. 440.91		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Bemchopneumonia DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Pneumococcosis DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia virus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the this hospital attended the deceased from 5/30 19 69 to July 1 19 69 , that we lost saw the deceased alive on July 1 19 69 and that in my our opinion death occurred on the date and hour and from the causes stated above. I We did did not view the body after death.					
23A. SIGNATURE H. C. Alevizatos M.D.				23B. DATE SIGNED July 1, 1969	
23C. PHYSICIAN'S NAME (Type) H. C. ALEVIZATOS, M.D.				23D. ADDRESS 1205 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 5, 1969		24C. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PK.	
24D. LOCATION (City, town, or county) BALTO. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR J. Shafter Conklin ADDRESS 5444 Belair Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6857	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LILLIAN HISS		July 5th, 1969 2:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5505 Greenleaf Road			A. STATE Maryland		B. COUNTY 2712
			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 5505 Greenleaf Road		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13th, 1890	9. AGE (In years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (Ret.)		10B. KIND OF BUSINESS OR INDUSTRY Public Health		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John C. Hiss		
14. MOTHER'S MAIDEN NAME Lillian Cochran			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 212-40-6082			17. INFORMANT Miss Mary C. Hiss-5505 Greenleaf Rd		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 4 1968 to May 17 1969, that (I) (we) last saw the deceased alive on May 17 1969 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RK Gundry				23B. DATE SIGNED 7-7-69	
23C. PHYSICIAN'S NAME (Type) RK GUNDY				23D. ADDRESS 2 W University Pkwy 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69		24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mitchell W. Deford	
				ADDRESS Home-6500 York Rd. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6858

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

69 6858

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph CULOTTA

2. DATE AND HOUR OF DEATH

July 4, 1969

5 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

**4551 Reisterstown Road
Baltimore, Maryland 21215**

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4551 Reisterstown Road

5. SEX

Male

6. RACE

Cauc.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

April 27, 1903

9. AGE (In years
last birthday)

66

10. Under 1 Yr.
Months Days

11. Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Produce Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Food

11. BIRTHPLACE (State or foreign country)

Ceflau, Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Culotta

14. MOTHER'S MAIDEN NAME

Salvatrice Culotta

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218 32 3836

17. INFORMANT

Baltimore, Maryland 21215

Mrs. Celia Culotta 4551 Reisterstown Road

18.

**DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH**

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Central thrombosis & Compas

(B) DUE TO, OR AS A CONSEQUENCE OF:

Senescent atherosclerosis degeneration

(C) DUE TO, OR AS A CONSEQUENCE OF:

Chronic brain syndrome

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **July 3** 19**69** to **July 4** 19**69**,
that (I) (we) last saw the deceased alive on **July 3** 19**69** and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Nathan E. Needle

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

7/6/69

23C. PHYSICIAN'S
NAME (Type)

Nathan E. Needle, M.D.

23D. ADDRESS

7111 Park Heights Avenue

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7 JUL 69

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1969

25B. NAME OF REGISTRAR

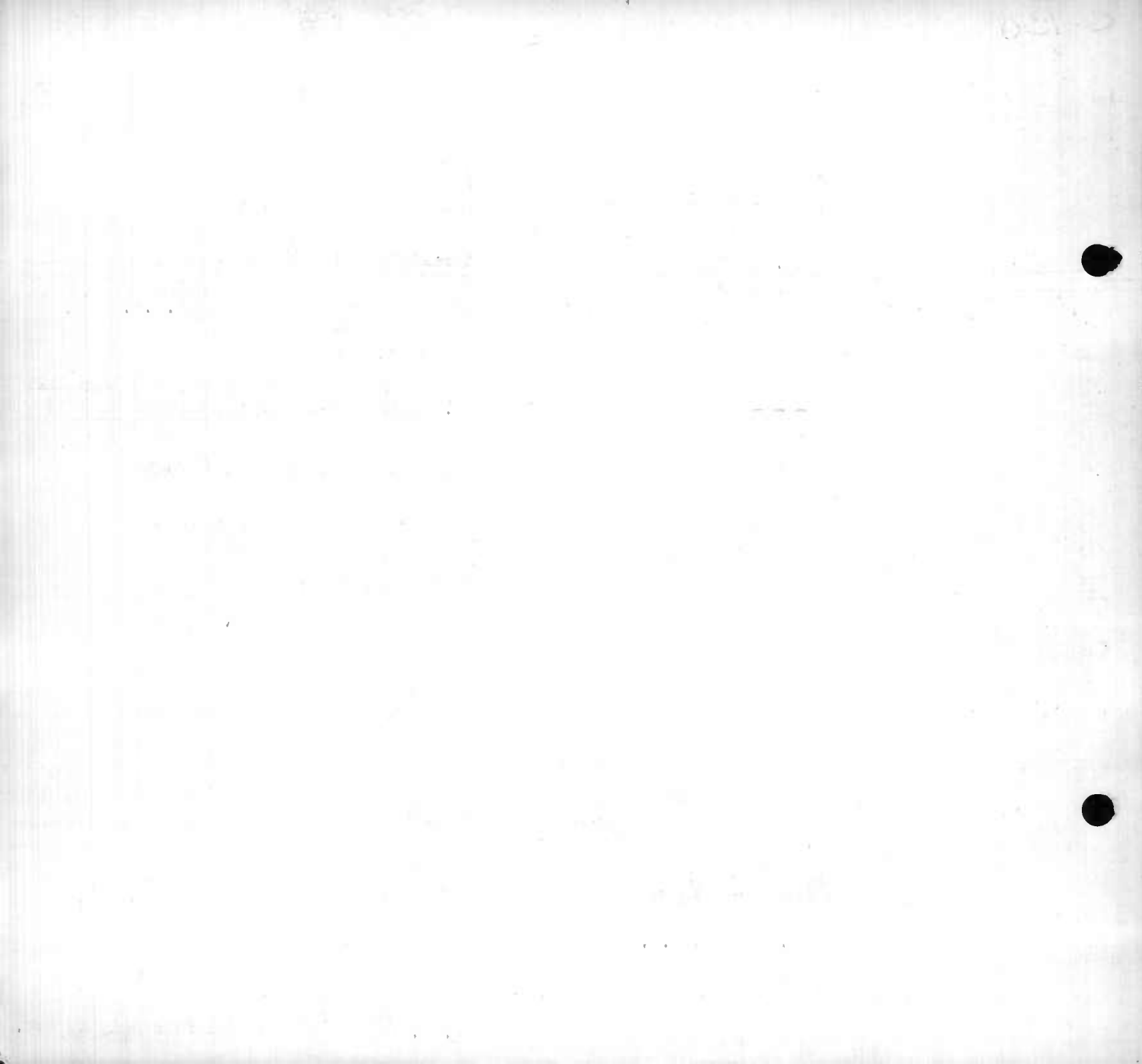
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Ed. Lovell Lemmon

ADDRESS

4611 Park Heights Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 6859 CERTIFICATE OF DEATH

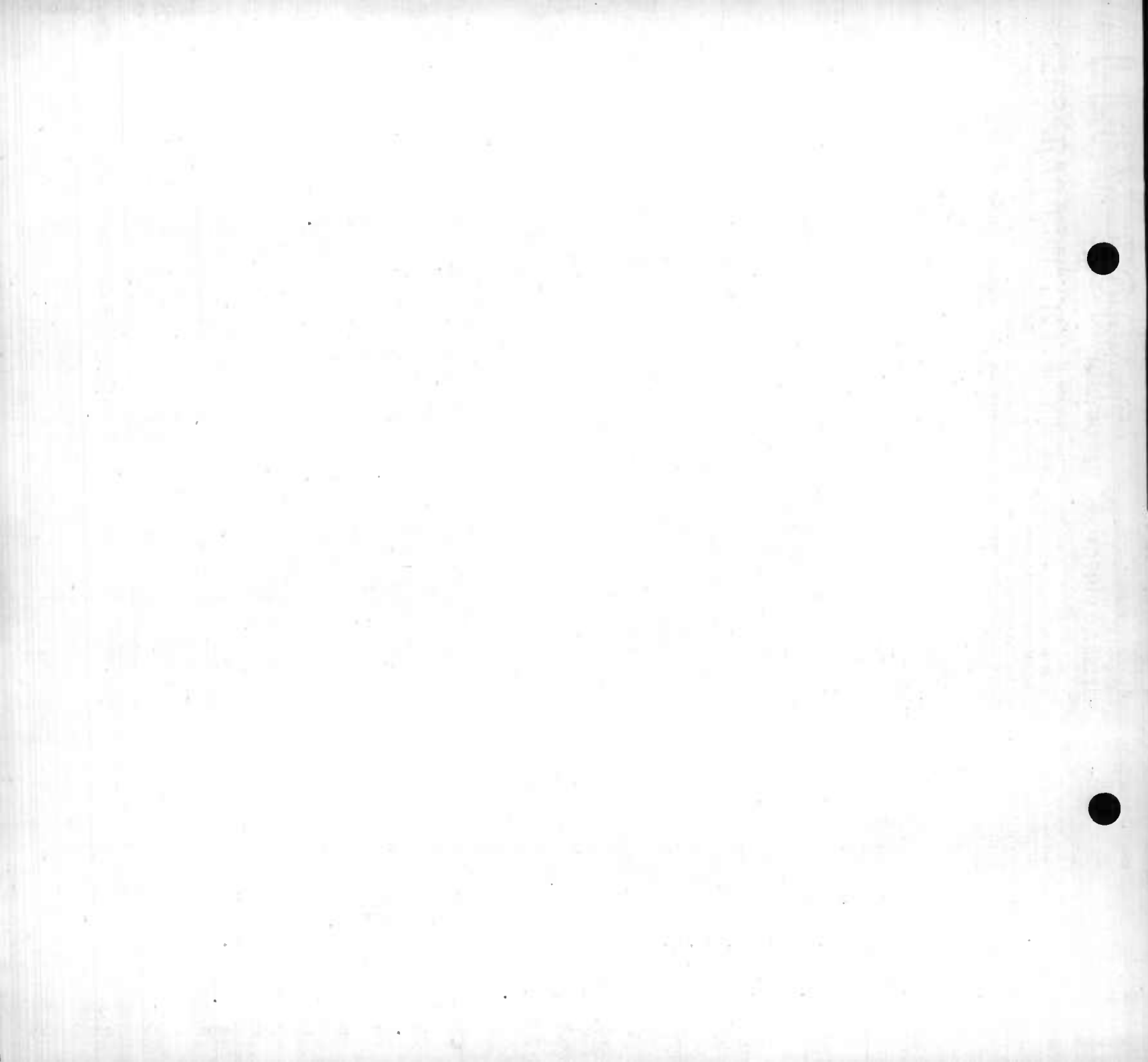
REG. NO. 69 6859

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Brookins, Gracie		2. DATE AND HOUR OF DEATH 6-28-69 2:20P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 1403	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1898	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		9. AGE (In years last birthday) 71 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CHART	
18. 4-36-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-22-69 at 6:00 p.m. 6-28-69 at 2:20 p.m.	
19A. DATE OF OPERATION 6-22-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-22-69 to 6-28-69 and that (I) (we) last saw the deceased alive on 6-28-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Corpuz, M.D.				23B. DATE SIGNED 6-28-69	
23C. PHYSICIAN'S NAME (Type) Ramundo R. Corpuz, M.D.		23D. ADDRESS 1514 Divison Street			
24A. BURIAL CREMATION, REMOVAL (Specify) 7/7/69		24B. DATE Burial		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetry	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Agolpus Halstead 1206 W north A			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6860
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anton Parada		July 6, 1969 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital			A. STATE Maryland B. COUNTY 2505		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1609 Locust St.		
5. SEX M	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1892	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY B&O	11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705 09 2740	17. INFORMANT Family		ADDRESS Same
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(B) Cerebral Sclerosis DUE TO, OR AS A CONSEQUENCE OF: Severe osteo-arthritis					
(C) Decubitus ulcers - large					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (did not) attended the deceased from 4/26/69 19 to 7/6/69 19, that (I) (do) last saw the deceased alive on 7/6/69 19 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (do) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 7/7/69	
23C. PHYSICIAN'S NAME (Type) Samuel Rubin, M.D.				23D. ADDRESS 203 E. Patapsco Avenue Baltimore, Md. 21225	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/69		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem.	
				24D. LOCATION (City, town, or county) Baltimore Md. (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1969		John H. Hahn		John H. Hahn Funeral Home 4200 Pennigton	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6861	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BESSIE STEELE REARRICK		7/5/69 9 ⁰⁰ P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived/ If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 HOUSE IN THE PINES (DELAIR ROAD)				MD BALTO. CO. 21222	
5. SEX		6. RACE		C. CITY OR TOWN	
FEMALE		WHITE		DUNDALK	
		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		8. DATE OF BIRTH		E. STREET AND NUMBER	
		SEPT. 11, 1894		75 WILLOW SPRING RD 5300	
		9. AGE (In years last birthday)		12. CITIZEN OF WHAT COUNTRY?	
		74		U. S. A	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				PENNA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
LABANIA STEELE				HARRIETT TURNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		217-01-4441D		CHARLES R. REARRICK	
		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Acute Cardiovascular Thrombosis		2 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Probable Cerebral Embolism		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Atrial Fibrillation - Fibrillation		—	
II		Left Hemiparesis		5 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Edema of lungs		5 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 6/16/1969 to 7/5/1969, that (I) (we) last saw the deceased alive on 7/2/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				7/5/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		7/8/1969		MEADOWRIDGE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1969		Robert E. Taylor M.D.		Walter Brook Bradley Inc. DUNDALK	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

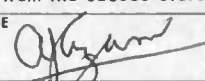
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

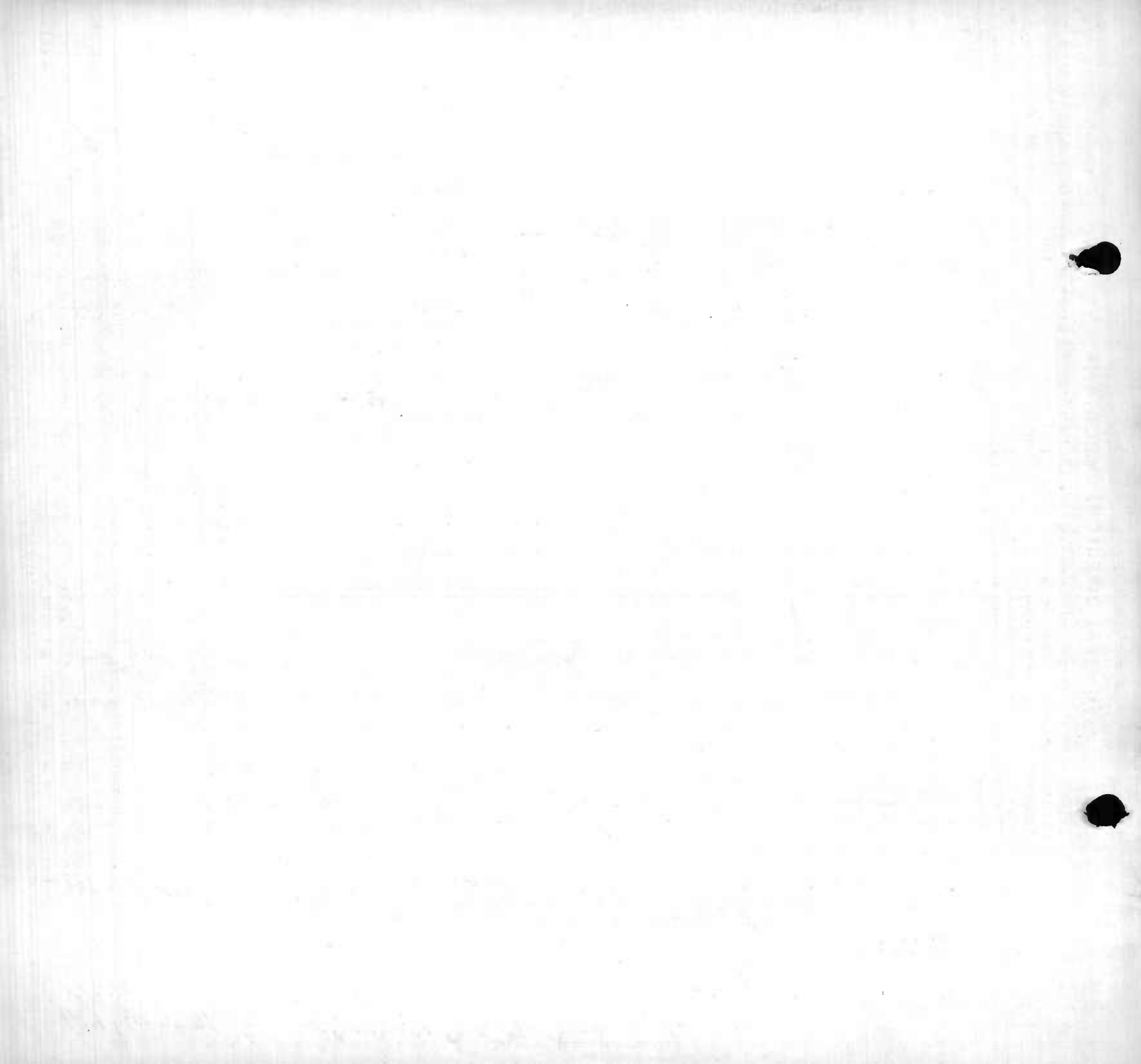
REG. NO.

69

6862

69 6862

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GLADYS VIRGINIA MARSHECK		2. DATE AND HOUR OF DEATH JULY 5, 1969 9:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE BALTIMORE CO. B. COUNTY	
C. CITY OR TOWN BALTIMORE DUNDALK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 3307 YORKWAY 21222 5300	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/99	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE, CLERK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PERRY REYNOLDS		14. MOTHER'S MAIDEN NAME SARAH L. CARTY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 32 1526		17. INFORMANT GLADYS V. ECHOLS - AS IN #4	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CARCINOMA LUNGS CARCINOMA BREASTS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Less than 1 yr. OVER 1 yr.	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____		_____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 17th Ago		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA BREASTS		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) DOES NOT APPLY		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) DOES NOT APPLY	
21D. TIME OF INJURY (APPROX.) DOES NOT APPLY		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> DOES NOT APPLY		21F. HOW DID INJURY OCCUR? DOES NOT APPLY	
22. I certify that (I) (this hospital) attended the deceased from 7/2/1969 to July 5th 1969 , that we last saw the deceased alive on July 5th 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) (did not) view the body after death.					
23A. SIGNATURE  MD DEGREE		23B. DATE SIGNED July 5th 1969		23C. PHYSICIAN'S NAME (Type) AHMAD FAROUK AZAM MD DEGREE	
23D. ADDRESS 100 N. BROADWAY BALTO. MD. 21231		24. NAME OF CEMETERY or CREMATORY DAK LAWN			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/1969		24C. LOCATION (City, town, or county) (State) BALTIMORE CO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Valerie E. Taylor, MD.		25C. FUNERAL DIRECTOR Robert J. Bradley, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was the regular attendant on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

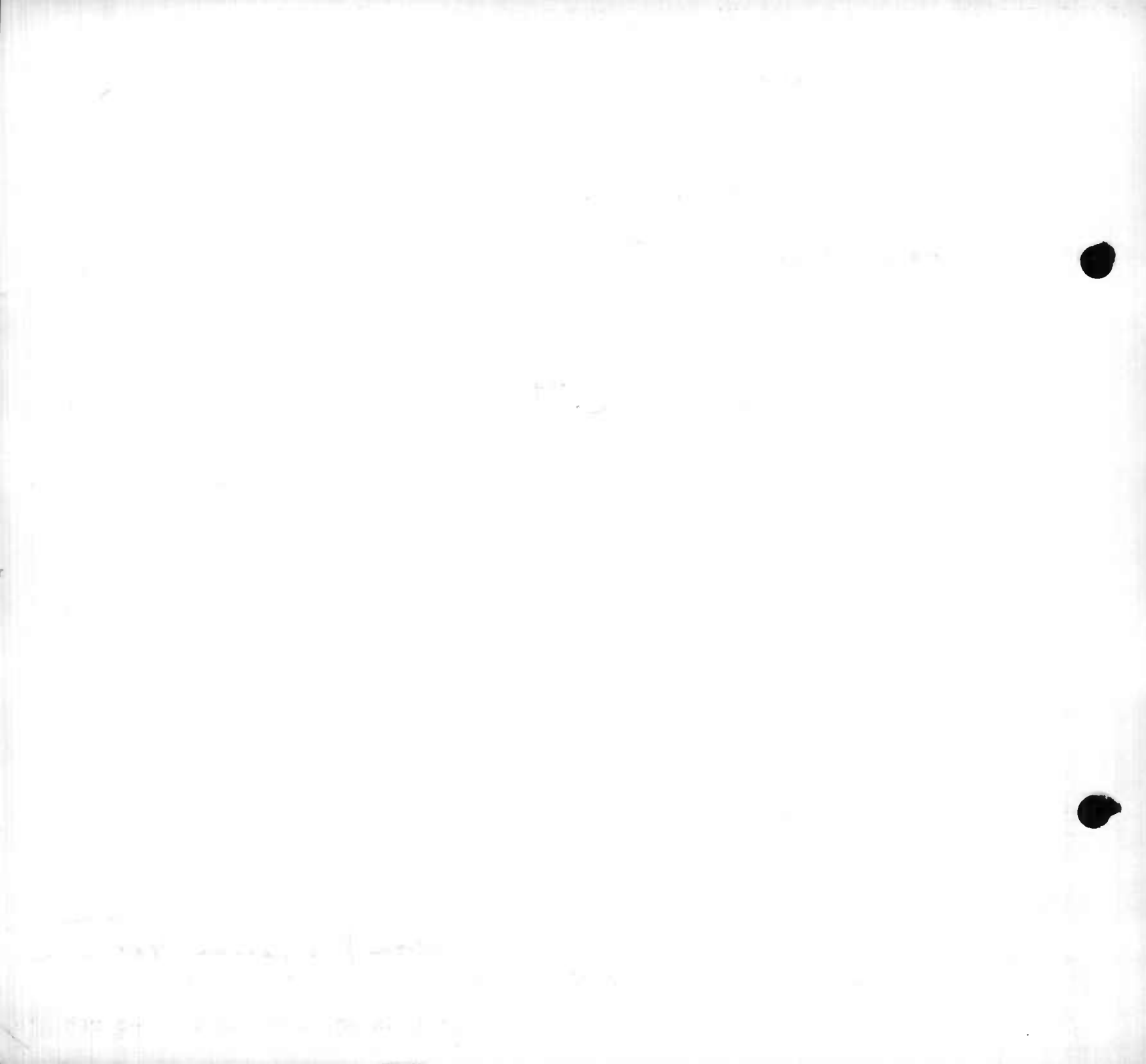
MBG 2

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6863	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DOBLE HOWARD		2. DATE AND HOUR OF DEATH 3 July 69 12 07 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALT.		5. CITY OR TOWN Balt. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2909 N. ROLLING RD.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/02	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maine	
13. FATHER'S NAME Eugene Doble		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 5-21017-8875		17. INFORMANT Mrs Norma C Doble Same as #E	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) pneumonia		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: chronic liver disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating the UNDERLYING CONDITION last. chronic alcoholism		(B) chronic liver disease DUE TO, OR AS A CONSEQUENCE OF: chronic alcoholism		years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fracture Left Femur				6/27/69	
19A. DATE OF OPERATION 6/27/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED #		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Indify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Balt. MD. 2909 N. ROLLING RD.	
21D. TIME OF INJURY (APPROX) 6 26 69 6pm		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? patient fell, in home	
22. I certify that (I) (this hospital) attended the deceased from 6/30 19 69 to 7/3 19 69 that (I) (we) last saw the deceased alive on 7/3 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas A. Otter MD.		23B. DATE SIGNED 7/3/69		23C. PHYSICIAN'S NAME (Type) THOMAS A. OTTER MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) B rial		24B. DATE 7/7/69		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	
24D. LOCATION Balt Co Maryland		24E. ADDRESS 601 N. Broadway, Balt MD.		24F. DATE REC'D BY HEALTH DEPT. JUL 8 1969	
25A. NAME OF REGISTRAR Wm Cook Brooks		25B. NAME OF REGISTRAR Wm Cook Brooks		25C. FUNERAL DIRECTOR 6212 Balt Nat'l Pike	
25D. ADDRESS Wm Cook Brooks West Inc Balt Md 21228		25E. ADDRESS Wm Cook Brooks West Inc Balt Md 21228		25F. ADDRESS Wm Cook Brooks West Inc Balt Md 21228	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6864</u>
BIRTH NO. <u>69 6864</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>AMOS, FRANCIS</u>		2. DATE AND HOUR OF DEATH <u>July 4th 1969</u> <u>7:40</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 THE UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2710</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>602 E 43RD ST.</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-7-16</u>	9. AGE (In years last birthday) <u>53</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>JAMES AMOS</u>		
14. MOTHER'S MAIDEN NAME <u>REBECCA JANE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW2</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>WILSON AMOS</u> ADDRESS <u>4407 St. George Av.</u>		
18. <u>485-X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Branchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>acute Pulmonary edema</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>D. H.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examined)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>May 19</u> 19 <u>69</u> to <u>July 4th</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>July 4th</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>J. Cohen V.</u> M.D. DEGREE Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>July 4th, 1969</u>
23C. PHYSICIAN'S NAME (Type) <u>CABRERA, JUAN M.</u> M.D. DEGREE				23D. ADDRESS <u>Union Memorial Hospital</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/10/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>National Cemetry</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>	25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>1206 W noerth Ave</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

69 6865

69 6865

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) FLORINE HARPER (LOMAX)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 5, 1969 10:30 am.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 422 Laurens St. D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1969 10:30 am.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9/10/27		10. AGE (in years last birthday) 42	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr James Rowe		ADDRESS 2608 E Oliver St	
19. 3 7/8		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty alteration of the liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____	
20A. DATE OF OPERATION 2/8/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 7/6/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69	
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. Jul 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

1/10/57

North Carolina

Unemployed

Mr. James Howe 2304 E. Oliver St.

RECEIVED BY MAIL

VALLEY

1/10/57

Mr. Colvin County

A. L. County

Abolitionist

T-612

69 6866 BALTIMORE CITY HEALTH DEPARTMENT

69 6866

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LINSAY TRAVIS

2. DATE
OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

July 6, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 6, 1969

10:15 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1205

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

9. DATE OF BIRTH

3/5/1927

10. AGE (In years
last birthday)

42

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

127 East North Avenue

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM E. TRAVIS

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

14B. KIND OF BUSINESS OR INDUSTRY

AUTO SALES

15. MOTHER'S MAIDEN NAME

MATTIE WIMBERLY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

Korean

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

WILLIAM E. TRAVIS 1416 W. FRANKLIN ST

19.

E 9651 X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of left chest
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

127 East North Ave. - Apt. 8C

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

7-6-69 10:03 A. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 7, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Buried

24B. DATE

7/12/69

24C. NAME OF CEMETERY or CREMATORY

MT Auburn

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1969

25B. NAME OF REGISTRAR

James E. Taylor, M.D.

25C. FUNERAL DIRECTOR

James E. Taylor, M.D. 638 N. Galloway St

ADDRESS

118731/9690006057

ACADEMY BOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 69 6867	
BIRTH NO. 69 6867		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VIRGINIA GRAY		2. DATE AND HOUR OF DEATH 7-7-69 1:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD B. COUNTY 1506			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL 7 MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 2740 BAKER ST 21210		E. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH NOV 18 1895	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Essex Co VA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Gray			
14. MOTHER'S MAIDEN NAME Harriet L. Gray		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Myrtle Wilkins 2740 Baker St			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CHRONIC BRAIN SYNDROME		INTERVAL BETWEEN ONSET AND DEATH MONTHS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar E. Fernandez M.D.				23B. DATE SIGNED 7-7-69	
23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDIN		23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/69		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Marjorie R. Hughes 3829 Guilford			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6868		BALTIMORE CITY HEALTH DEPARTMENT		69 6868	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) EDWARDS JAMES BYRON		2. DATE AND HOUR OF DEATH 07 05 69 6:09 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVES BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 338 S. BENTALOU ST			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03 31 01	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY AUTO MECHANIC		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES EDWARDS DEC'D			
14. MOTHER'S MAIDEN NAME DAISY GUY DEC'D		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 217 01 5227		17. INFORMANT ST AGNES HOSPITAL RECORDS ADDRESS			
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular Fibrillation (B) Emphysema, DUE TO, OR AS A CONSEQUENCE OF: (C) Congestive heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 5 19 69 to JULY 5 19 69 that (X) (we) last saw the deceased alive on JULY 5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Shams M.D.		23B. DATE SIGNED 7-5-69		23C. PHYSICIAN'S NAME (Type) A. SHAMS	
23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 7-8-69		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR J. E. Taylor, M.D.		25C. FUNERAL DIRECTOR W. B. Schwab 2101 Eudick Ave	

1971-1972

1972-1973

1973-1974

1974-1975

1975-1976

1976-1977

1977-1978

1978-1979

1979-1980

1980-1981

1981-1982

1982-1983

1983-1984

1984-1985

1985-1986

1986-1987

1987-1988

1988-1989

1989-1990

1990-1991

1991-1992

1992-1993

B200

69 6865

BALTIMORE CITY HEALTH DEPARTMENT

69 6865

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANGELINA BECCIO		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 7, 1969 Hour 4:05 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year July 7, 1969 Hour 4:05 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2734		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	E. STREET AND NUMBER 3603 Frankfort Avenue
9. DATE OF BIRTH 2/16/75	10. AGE (In years lost birthday) 94	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Nicolas CITTIA		14. MOTHER'S MAIDEN NAME Nancy SOCCA	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		16. KIND OF BUSINESS OR INDUSTRY HOME	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fracture of right clavicle		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3603 Frankfort Ave. (inside steps)	
22D. TIME OF INJURY (APPROX.) 7-6-69 9:15 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Fell down steps		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DATE SIGNED July 7, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/10/69	24C. NAME OF CEMETERY or CREMATORY Sacred Heart	24D. LOCATION (City, town, or county) (State) Baltimore Md
25A. DATE REC'D BY HEALTH DEPT. 7/18 1969	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Joseph A. Ziemann	ADDRESS 263 S. Hollen

STATE OF TEXAS
COUNTY OF DALLAS

NOTARY PUBLIC

My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

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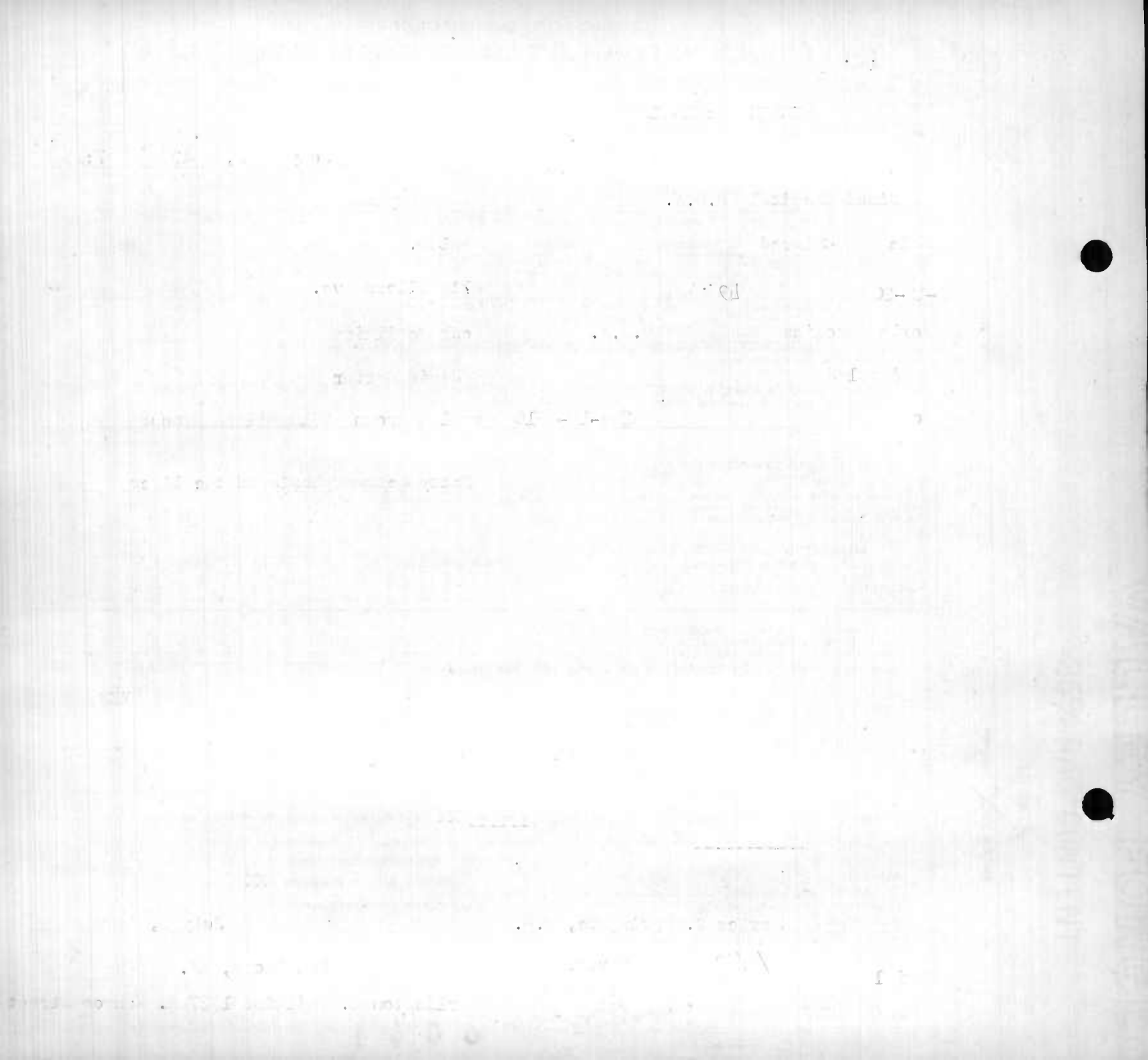
My Comm. Expires

69 6870 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 69 6870

BIRTH NO.

REG. NO.

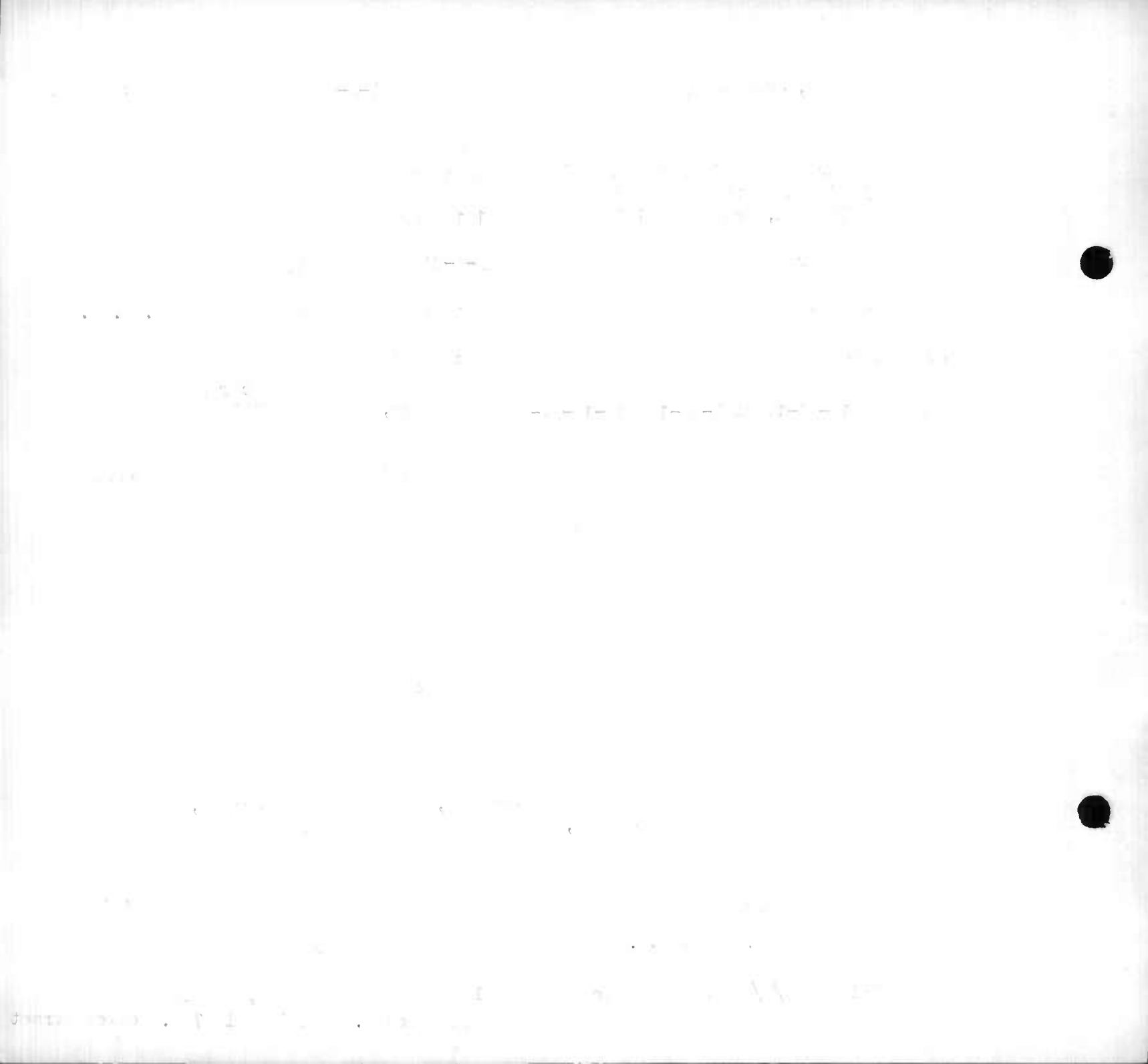
1. NAME OF DECEASED (Type or Print) WILLIE McMILLIAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1969 7:33 am.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 6-12-20		10. AGE (In years lost birthday) 49	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 244-10-6510	
18. INFORMANT Carolyn Brown		ADDRESS 4710 Wilern Avenue	
19. CAUSE OF DEATH 5-71.81		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty metamorphosis of the liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69	
24C. NAME OF CEMETERY or CREMATORY Arbutus		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

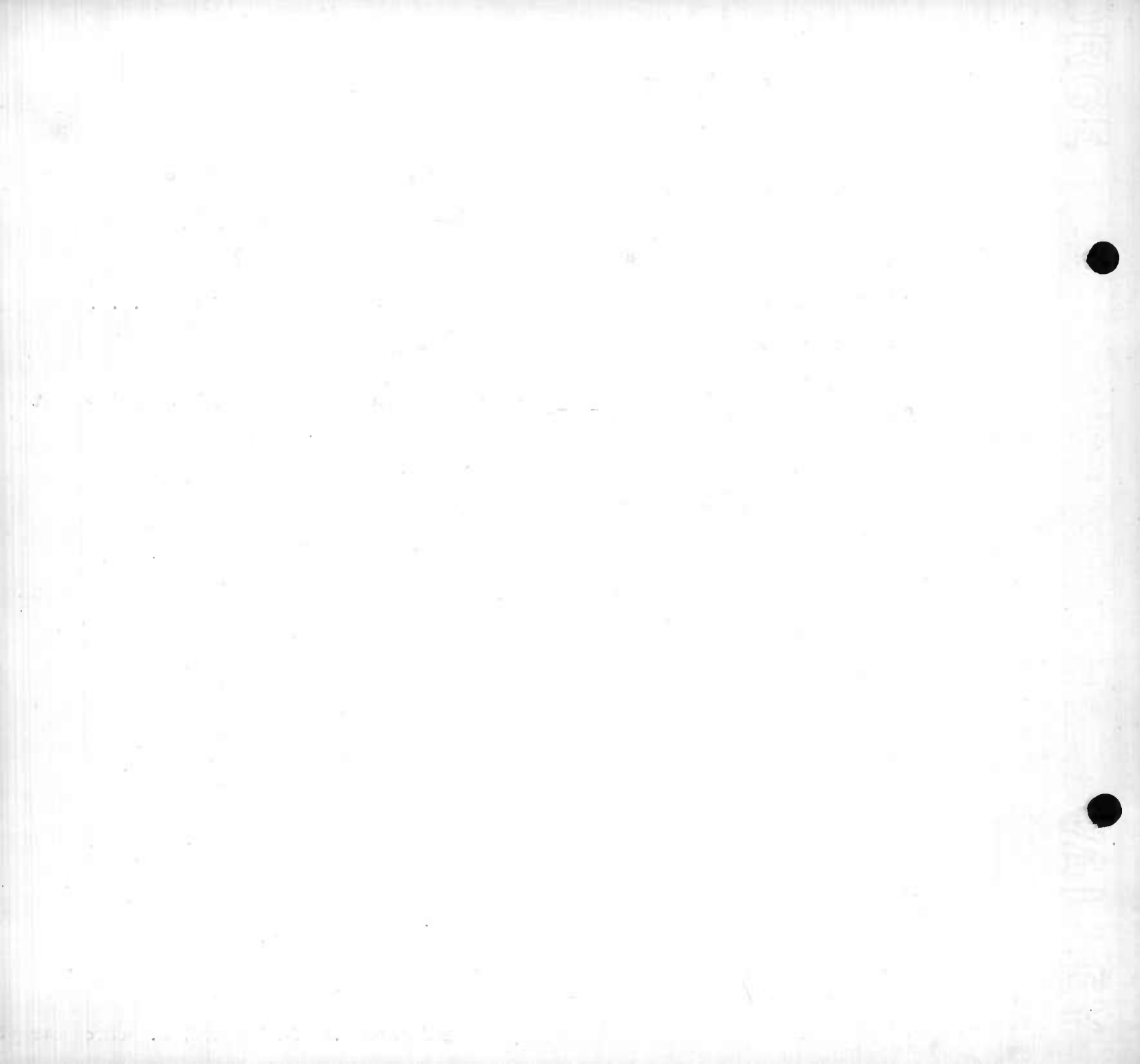
BIRTH NO. 69 6871		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 6871	
1. NAME OF DECEASED (Type or Print) WESTON, John Henry			2. DATE AND HOUR OF DEATH 7-2-69 4:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1502		
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male			6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-4-94			9. AGE (in years last birthday) 75		10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolas Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME John Weston		
14. MOTHER'S MAIDEN NAME Rachel Diggs			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-24-17 to 7-26-19		
16. SOCIAL SECURITY NO. 216-12-56-86			17. INFORMANT VA Hospital Records Baltimore, Maryland 21218		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of the liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 1977-8 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 24, 1969 to July 2, 1969 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 2, 1969 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) not view the body after death.					
23A. SIGNATURE Young E. Chun, M.D.			23B. DATE SIGNED July 3, 1969		23C. PHYSICIAN'S NAME (Type) YOUNG E. CHUN, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/7/69		24C. NAME of CEMETERY or CREMATORY Baltimore National
24D. LOCATION Baltimore, Maryland			25A. DATE RECEIVED BY HEALTH DEPT. JUL 8 1969		
25B. NAME OF REGISTRAR Phillips			25C. FUNERAL DIRECTOR Arlington S. Phillips		
ADDRESS 1727 N. Monroe Street					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

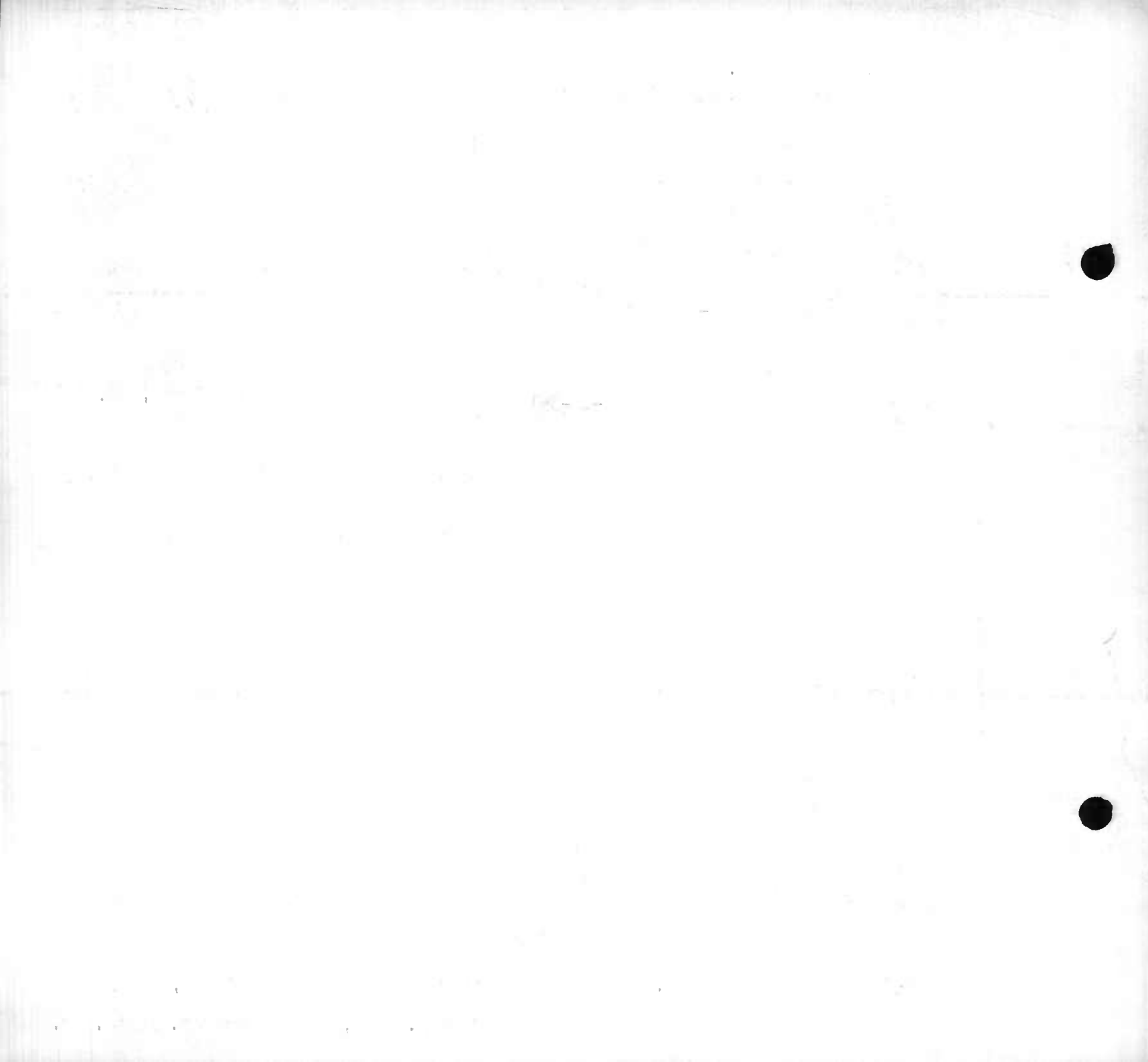
BALTIMORE CITY HEALTH DEPARTMENT									
69 6872					6872				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) Josephine Scott					2. DATE AND HOUR OF DEATH July 2, 1969 9:15 a M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 00 2211 Saratoga Street					A. STATE Maryland B. COUNTY Baltimore				
					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 2211 Saratoga Street				
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1892	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Rufus Williamson			14. MOTHER'S MAIDEN NAME Dellie Norman						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-10-1764		17. INFORMANT James Calloway		ADDRESS 2211 Saratoga Street		
18. 424.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one day				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C. valvular disease of heart					DUE TO, OR AS A CONSEQUENCE OF: 15 years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerosis					10 years				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8-17-1956 to 7-2-1969 , that (I) had last saw the deceased alive on July 1 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) do (did) not view the body after death.									
23A. SIGNATURE John E. J. Camper, M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-3-69		
23C. PHYSICIAN'S NAME (Type) JOHN E. J. CAMPER, M.D.					23D. ADDRESS 639 E. Green St. Baltimore Maryland 21217				
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY OR CREMATORY Mount Calvary		24D. LOCATION (City, town, or county) (State) Anne Arundel County			
25A. DATE RECD BY HEALTH DEPT. JUL 8 1969					25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS 4110 S. 3 Phillips 1727 N. Monroe Street		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

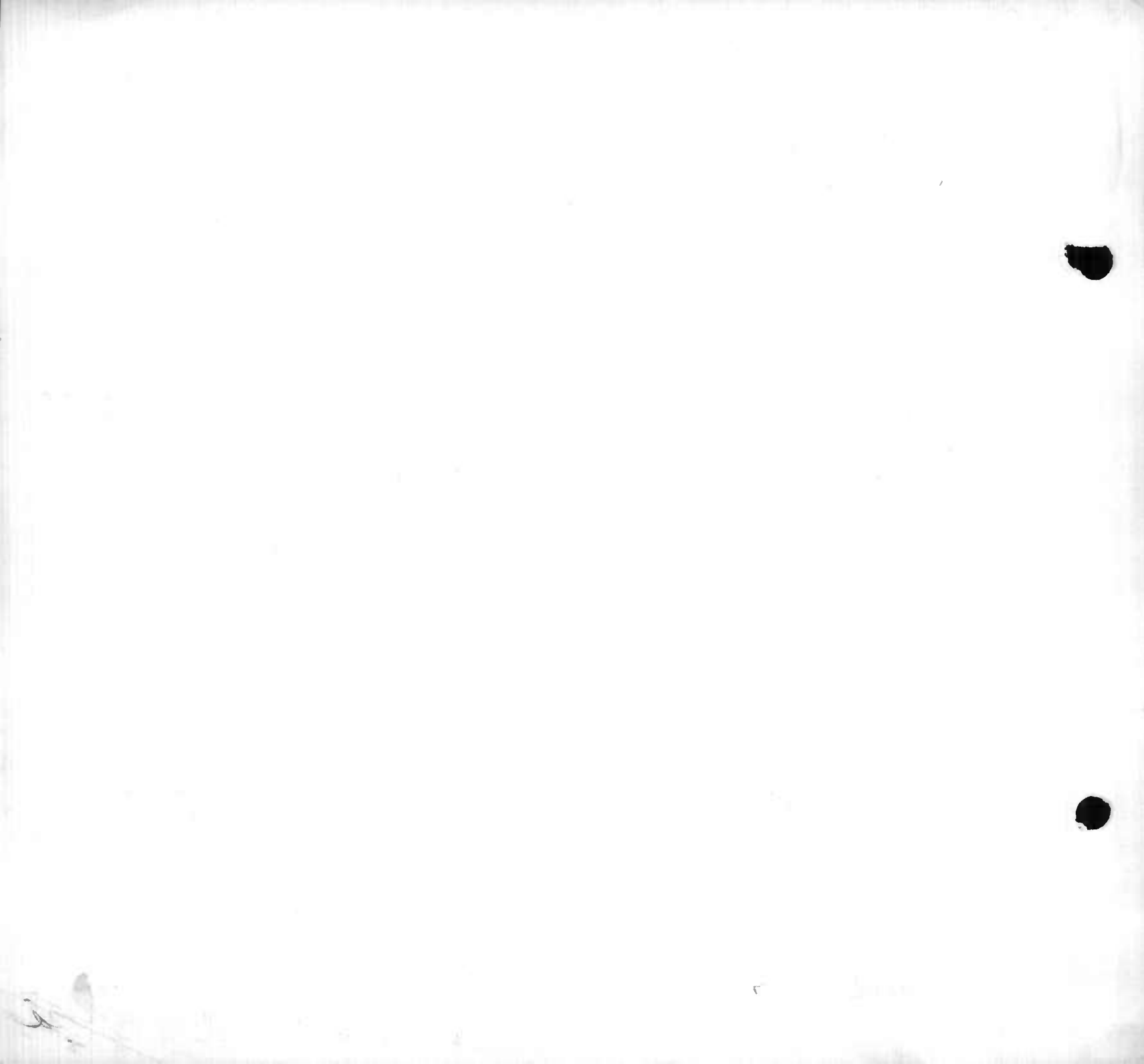
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6873	
69 6873 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Felix S. (Phillip) Zelechowski (Zeller)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		DATE AND HOUR OF DEATH 6:05 PM 7/5/69			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
38 UNIVERSITY Hospital		A. STATE MD. B. COUNTY Baltimore			
5. SEX Male 6. RACE White		C. CITY OR TOWN Overlea		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 22 ELMONT AVE			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH AUG 3, 1914		9. AGE (In years last birthday) 54	
DOCK FOREMAN - Consolidated Freightways		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FELIX ZELECHOWSKI		14. MOTHER'S MAIDEN NAME FELIXIA SIARKOWSKI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-01-3913		17. INFORMANT (Wife) HALEN ZELECHOWSKI ADDRESS Baltimore, Md. 21206 22 ELMONT	
18. 204.01		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GRAM NEGATIVE SEPSIS		1 WK	
ANTECEDENT CAUSES		(B) ACUTE LYMPHOCYTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF:		3 YRS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		None.	
19A. DATE OF OPERATION 3/2/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAPAROTOMY		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from 6/27 19 69 to 7/5 19 69 that (1) (we) last saw the deceased alive on 7/5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Fleegler M.D.		23B. DATE SIGNED 7/5/69			
23C. PHYSICIAN'S NAME (Type) Bruce Fleegler		23D. ADDRESS MD. UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/69		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 2829 Hudson St. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6874 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6874	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MOORE AMANDA L.		2/7/69 10:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			A. STATE B. COUNTY MARYLAND BALTIMORE 2744		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER GLENHORE AVENUE 3619		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-02	9. AGE (in years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES			13. FATHER'S NAME OLEARY DESMOND		
14. MOTHER'S MAIDEN NAME RACHEL BARNES			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 215-30-0060			17. INFORMANT CHARLES Richter		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			19. IMMEDIATE CAUSE (A) IMMEDIATE CAUSE EXTENSIVE ANTI-MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 2nd 1969 to July 2nd 1969 that (I) (we) lost saw the deceased alive on July 2nd 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Cabrera			23B. DATE SIGNED 7-2-69		
23C. PHYSICIAN'S NAME (Type) JUAN CABRERA, M.D.			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/7/69		
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.			24D. LOCATION (City, town, or county) (State) Baltimore Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			25B. NAME OF REGISTRAR J. H. H.		
25C. FUNERAL DIRECTOR J. H. H.			25D. ADDRESS 7401 Belair Rd Baltimore Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6875	
BIRTH NO.		69 6875		69 6875	
1. NAME OF DECEASED (Type or Print) Helen Lamb Hull			2. DATE AND HOUR OF DEATH 7/2/1969 2:30 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 304 E. Melrose Ave			A. STATE Md. B. COUNTY Balto.		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 304 E. Melrose Ave		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1729/1875	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Eli M. Lamb		14. MOTHER'S MAIDEN NAME Anna W. Cockran	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 46 4249		17. INFORMANT ADDRESS Theo. E. Baker 304 E. Melrose Ave	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stroke ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Age- 94 Arteriosclerotic - Cardio-vascular disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 11 1961 to July 1 1969 , that (I) (we) last saw the deceased alive on July 1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charlotte McCarthy M.D.				23B. DATE SIGNED July 3, 1969	
23C. PHYSICIAN'S NAME (Type) CHARLOTTE MCCARTHY, M.D.				23D. ADDRESS 2919 St. Paul St., Balto. 18, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME OF CEMETERY or CREMATORY Friends Burial Ground	
24D. LOCATION (City, town, or county) (State) Harford Rd. Balto Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR Robert E. Baker, M.D.		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 89 6876
BIRTH NO.		69 6876		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		OSCAR CHARLES CURREY		2. DATE AND HOUR OF DEATH July 1, 1969 6 10 PM M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE S. MAIN STREET, FEDERALSBURG, Md. B. COUNTY Caroline Co.		
FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL 45		C. CITY OR TOWN Federalsburg, Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 218 South Main Street		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-90	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Day Laborer - Maryland Plastics, Inc.		10B. KIND OF BUSINESS OR INDUSTRY MICHIGAN		11. BIRTHPLACE (State or foreign country) U.S.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Oliver C. Currey		
14. MOTHER'S MAIDEN NAME Hattie (maiden name unknown)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-28-4844		17. INFORMANT Oscar C. Currey, Jr., Federalsburg, Md.		
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Lung Disease		
		(B) ASCVD		
		(C) 20 years		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from April 1 19 69 to July 1 19 69 , that (2) (we) last saw the deceased alive on July 1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE John V. Russo M.D.		23B. DATE SIGNED July 1, 1969		23C. PHYSICIAN'S NAME (Type) John V. Russo M.D.
23D. ADDRESS		23E. FUNERAL DIRECTOR Frank J. Branton Jr.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 1969		24C. NAME OF CEMETERY or CREMATORY Hill Crest Cemetery
24D. LOCATION (City, town, or county) Federalsburg, Maryland		24E. STATE Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR John E. Taylor M.D.		25C. FUNERAL HOME Federal Home, Federalsburg, Md.

FUNERAL DIRECTOR: IMPORTANT

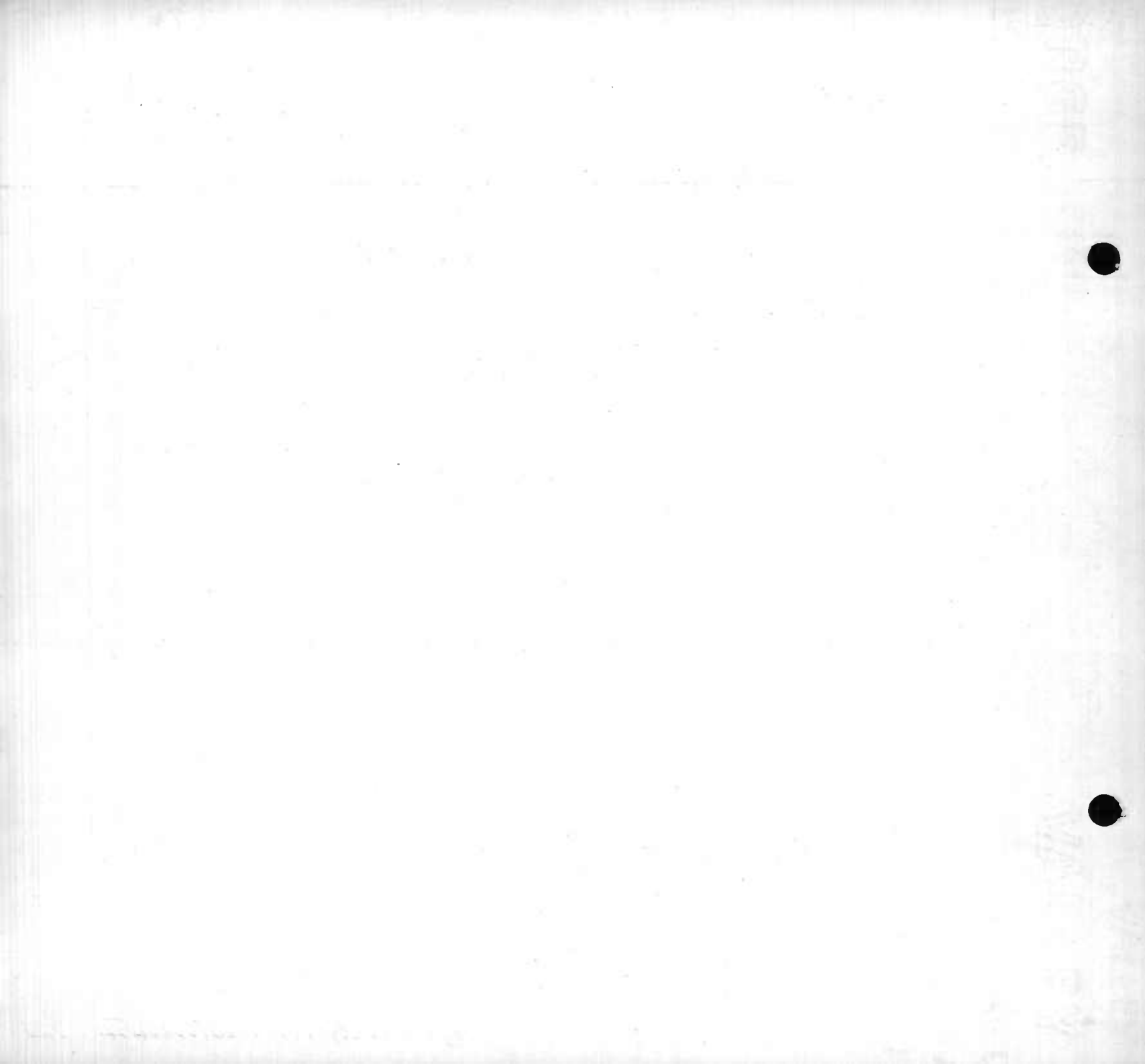
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6877

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 2769 6877

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Gist, Thomas W.</u>		2. DATE AND HOUR OF DEATH <u>7/1/69</u> <u>11:00</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>CARROLL CO.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HARBOR VIEW CON. CENTER</u> <u>1213 Light St.</u>		C. CITY OR TOWN <u>WESTMINSTER</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE AND FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>6/29/1881</u>	
13. FATHER'S NAME <u>BENJAMIN F. GIST</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ELIZABETH HOOK</u>		9. AGE (In years lost birthday) <u>88</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-14-6407</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
17. INFORMANT <u>CHARLES W. GIST</u>		ADDRESS <u>Rt 7 - Box 186 West. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
18. <u>03891</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Arteriosclerosis</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>June 17</u> 19 <u>69</u> to <u>July 1</u> 19 <u>69</u> , that <u>Dr.</u> (we) lost saw the deceased alive on <u>July 1</u> 19 <u>69</u> and that in <u>our</u> (my) opinion death occurred on the date and hour and from the causes stated above. <u>Dr.</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A.C. Alevisatos, M.D.</u>				23B. DATE SIGNED <u>July 1, 1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>A.C. ALEVISATOS, M.D.</u>		23D. ADDRESS <u>1209 St. Paul St Baltimore Md 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/5/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>DEER PARK METH. CEM. SMALLWOOD (CARROLL CO. MD)</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		25B. NAME OF REGISTRAR <u>James C. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. S. Ryer, Jr., Westminster, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

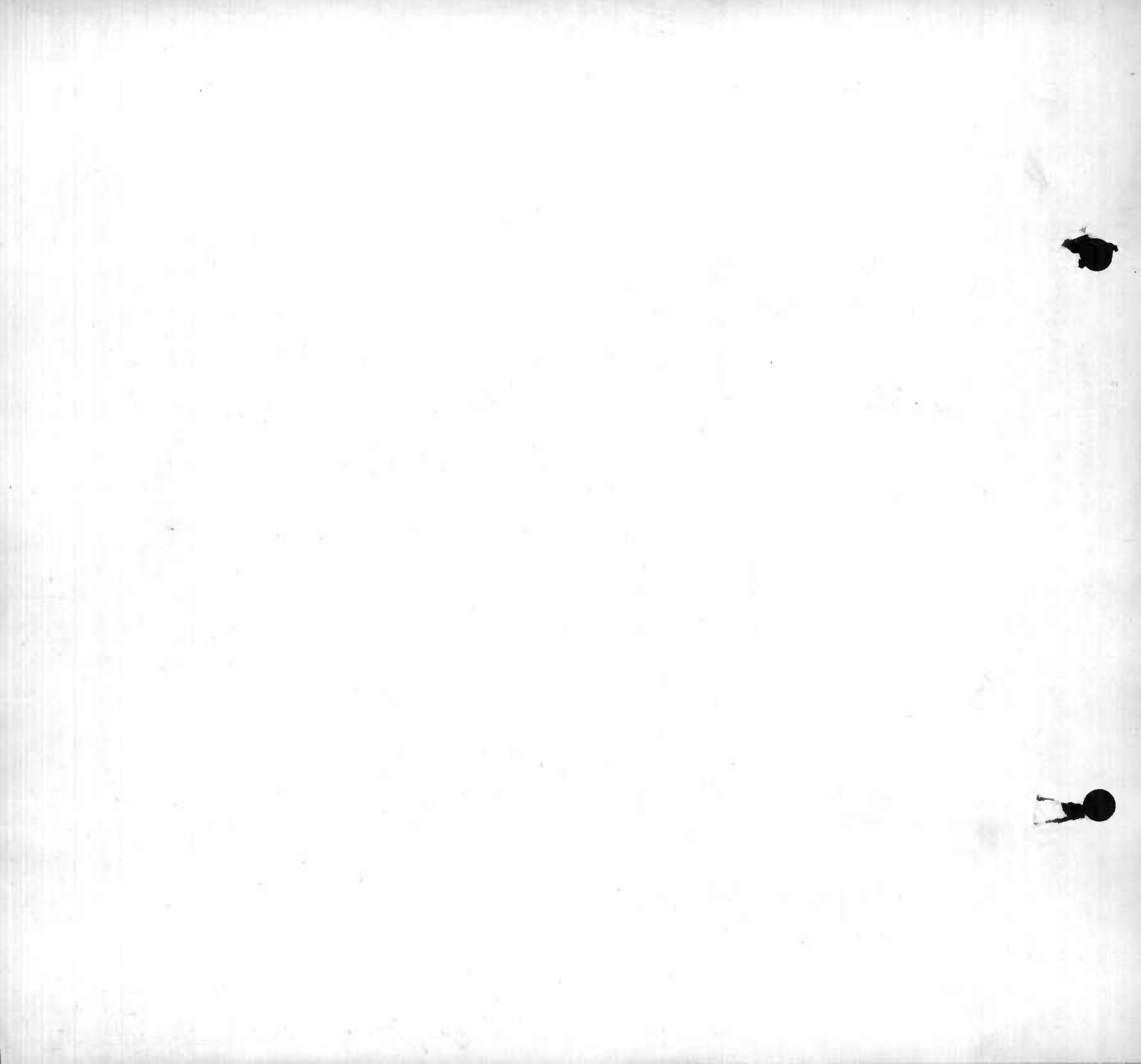
BIRTH NO. 69 6878				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 6878	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				George H. Martin		July 4 / 69 50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md.		B. COUNTY 1306	
00 3344 Hickory Ave.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		3344 Hickory Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	White	Widowed	1/2/1880	89			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Boiler Worker		Penn Central		Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Richard Martin				? Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		717-07-7154		Roland Martin - 3344 Hickory Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
412.41		ASCVD + Congestive failure		2 years			
ANTECEDENT CAUSES		(A) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO					
		(C) Chronic bronchitis + erythema		20 years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (M.D. or N.E.C.) attended the deceased from June 19 1951 to July 4 1969. that (I) (M.D.) last saw the deceased alive on July 4 1969 and that in (my) (or) opinion death occurred on the date and hour and from the causes stated above. (I) (M.D.) (or) view the body after death.							
23A. SIGNATURE Leonard Wallenstein M.D.				23B. DATE SIGNED 7/5/69			
23C. PHYSICIAN'S NAME (Type) LEONARD WALLENSTEIN M.D.				23D. ADDRESS 848 W 36th BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/7/69		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Ann Donovan M.D.		25C. FUNERAL DIRECTOR ADDRESS Ann Donovan - 3818 Roland Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6879	
BIRTH NO. 69 6879		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Rose Wagner</u>		2. DATE AND HOUR OF DEATH <u>July 4, 1969 8:20 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Whole deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2551</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-17</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lat Bander</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Lat Co.</u>		9. AGE (In years lost birthday) <u>52 yrs</u>	
13. FATHER'S NAME <u>James LaScola</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>15381</u>		17. INFORMANT <u>Charles S. WAGNER, JR.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Carcinoma of the Colon</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>5/19/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>lung cancer</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-19-69</u> 19 <u>69</u> to <u>7/4</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>7/4</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gonzalo F. Guacena, Jr.</u>		23B. DATE SIGNED <u>7/4/69</u>		23C. PHYSICIAN'S NAME (Type) <u>GONZALO F. GUACENA, JR.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/7/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		25B. NAME OF REGISTRAR <u>James E. Baker, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Gorman, Inc.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24E. ADDRESS <u>901 Hallens St. 21229</u>			



B-320

69 6880 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6880

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
		LILLIE BATES		July 3, 1969		11:15 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		3. DATE PRONOUNCED DEAD Month Day Year		July 3, 1969		11:15 P.M.			
36 Franklin Square Hospital		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE		Maryland		1902			
6. SEX Female		7. RACE White		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 27, 1885		10. AGE (In years lost birthday) 84		E. STREET AND NUMBER 111 South Calhoun Street					
11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Emory H Bates					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk		14B. KIND OF BUSINESS OR INDUSTRY Laundry		15. MOTHER'S MAIDEN NAME Mary A Read					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 212 52 5864		18. INFORMANT Anna C Randolph		ADDRESS 5004 Eutaw Place College Park, Md.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION 5-6-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural hematoma		21. AUTOPSY? (Yes or No) Yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unknown		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) Unknown		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Presumably fell									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 4, 1969					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 8, 1969		24C. NAME OF CEMETERY or CREMATORY St Johns Cemetery		24D. LOCATION (City, town, or county) (State) Beltsville Pro Geo Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Miss E. J. Bay, M.D.		25C. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.			

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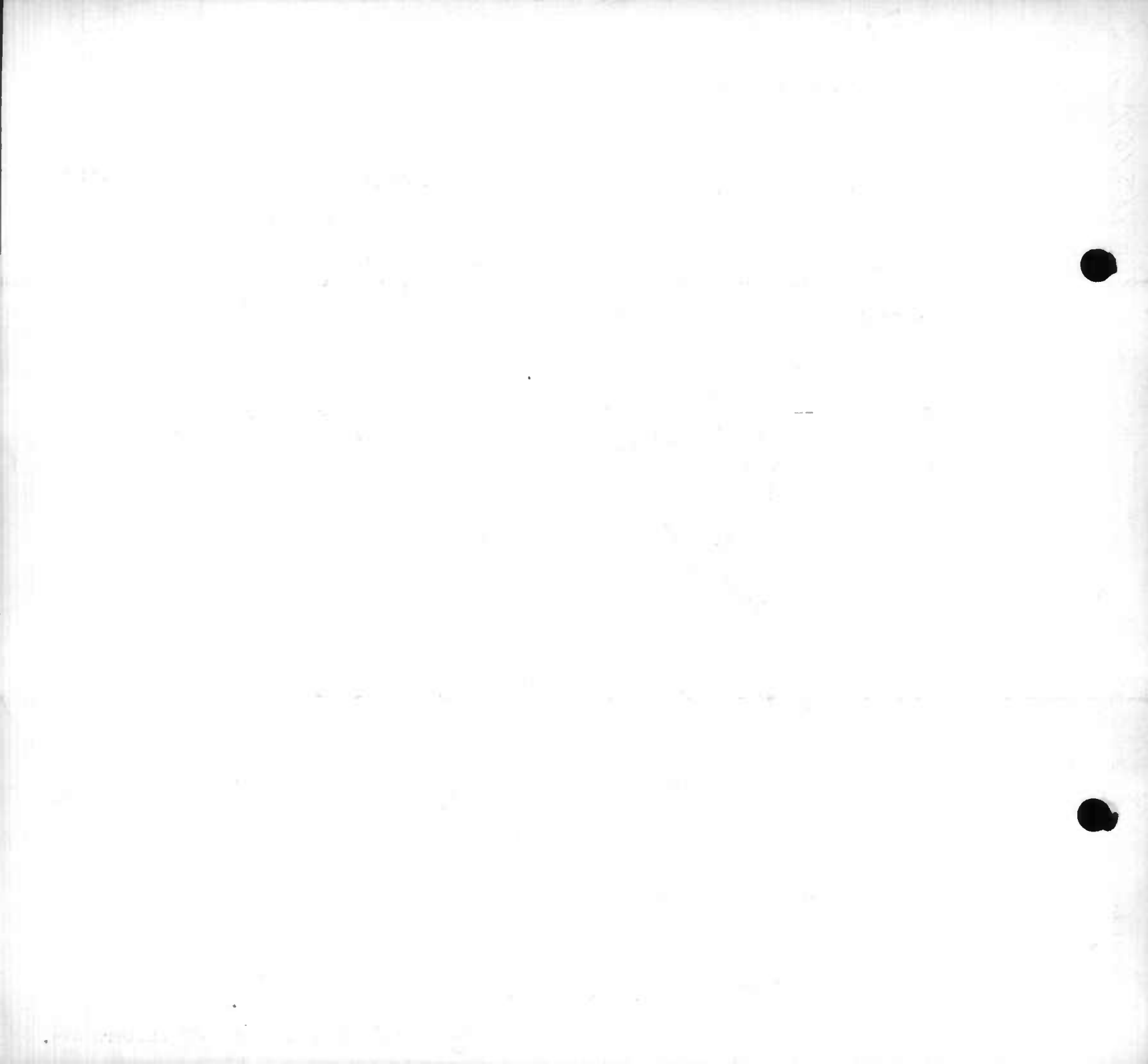
ACADEMIC BOARD

Released and approved by M.D. Examiner 8/5/69 7/3/69 G.D. 2.2.2.2

FUNERAL DIRECTOR: IMPORTANT

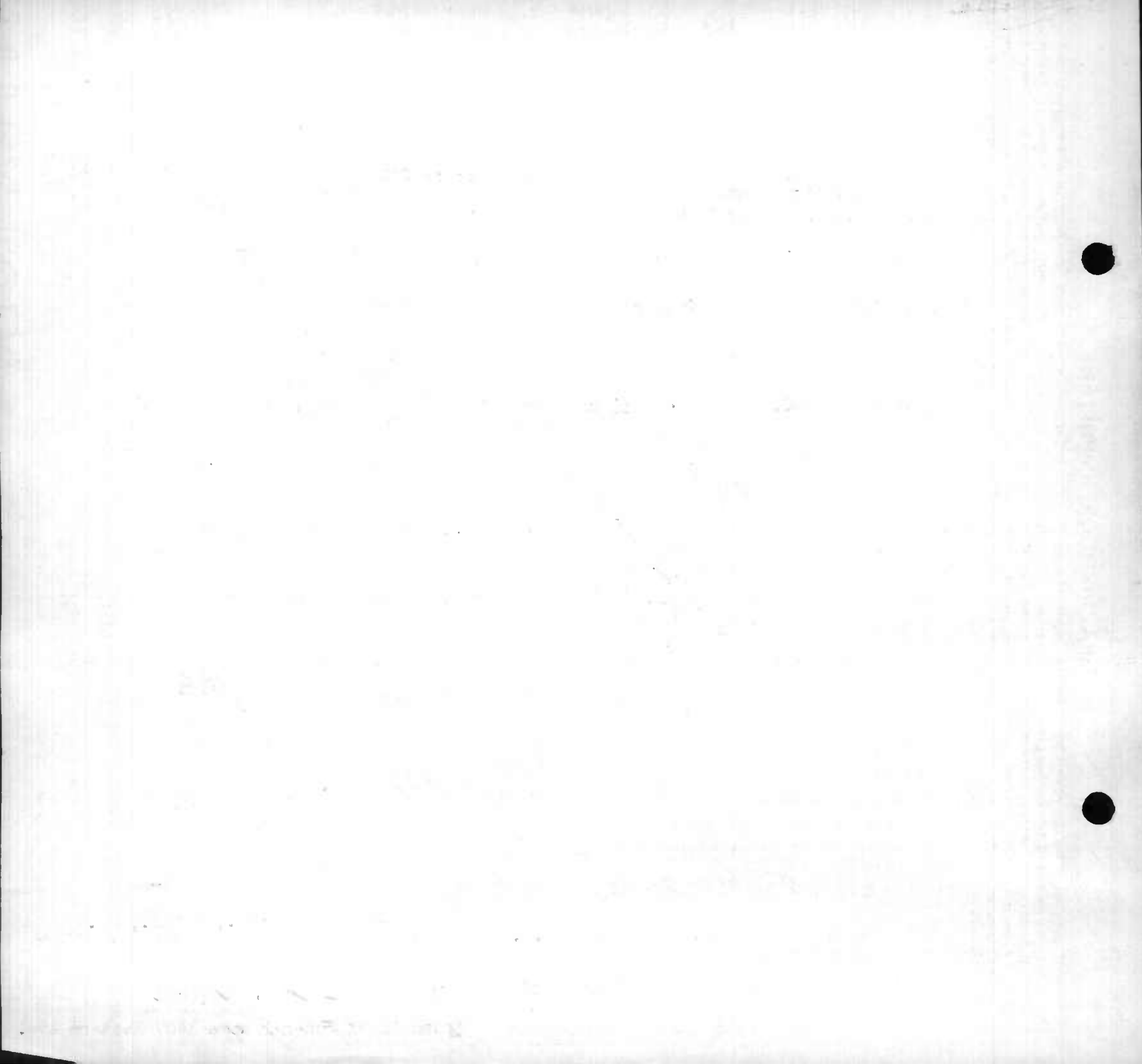
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
5-530 69 6881				69 6881	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CARRIE G. SMITH		2. DATE AND HOUR OF DEATH 7-3-69		5:45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL		C. CITY OR TOWN ESSEX 21221		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1631 POLKS ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-1927	9. AGE (In years last birthday) 42	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME LOUIS LOHMAN		14. MOTHER'S MAIDEN NAME MRS. MARGARET LUGENBACH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 36-0639		17. INFORMANT Margaret Dellinger Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ACUTE MYOCARDIAL INFARCTION		19. CAUSE OF DEATH PULMONARY EMBOLISM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
(This does not mean the mode of death, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: TRACTION OF LEFT FEMUR		(B) DUE TO, OR AS A CONSEQUENCE OF: ACCIDENTAL FALL	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause, including the UNDERLYING CONDITION last.		(C) ACCIDENTAL FALL			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6-7-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACTION OF LEFT FEMUR		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1631 POLKS ROAD 53-00	
21D. TIME OF INJURY (APPROX.) 6-7-69 11:00 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? SUDDEN FALL	
22. I certify that (I) (this hospital) attended the deceased from 6-7-69 19 69 to 7-3 19 69 that (I) (we) lost saw the deceased alive on 5:45 AM 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose M. de Leon, M.D.				23B. DATE SIGNED 7-3-69	
23C. PHYSICIAN'S NAME (Type) JOSE M. DE LEON, MD				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR Wm. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

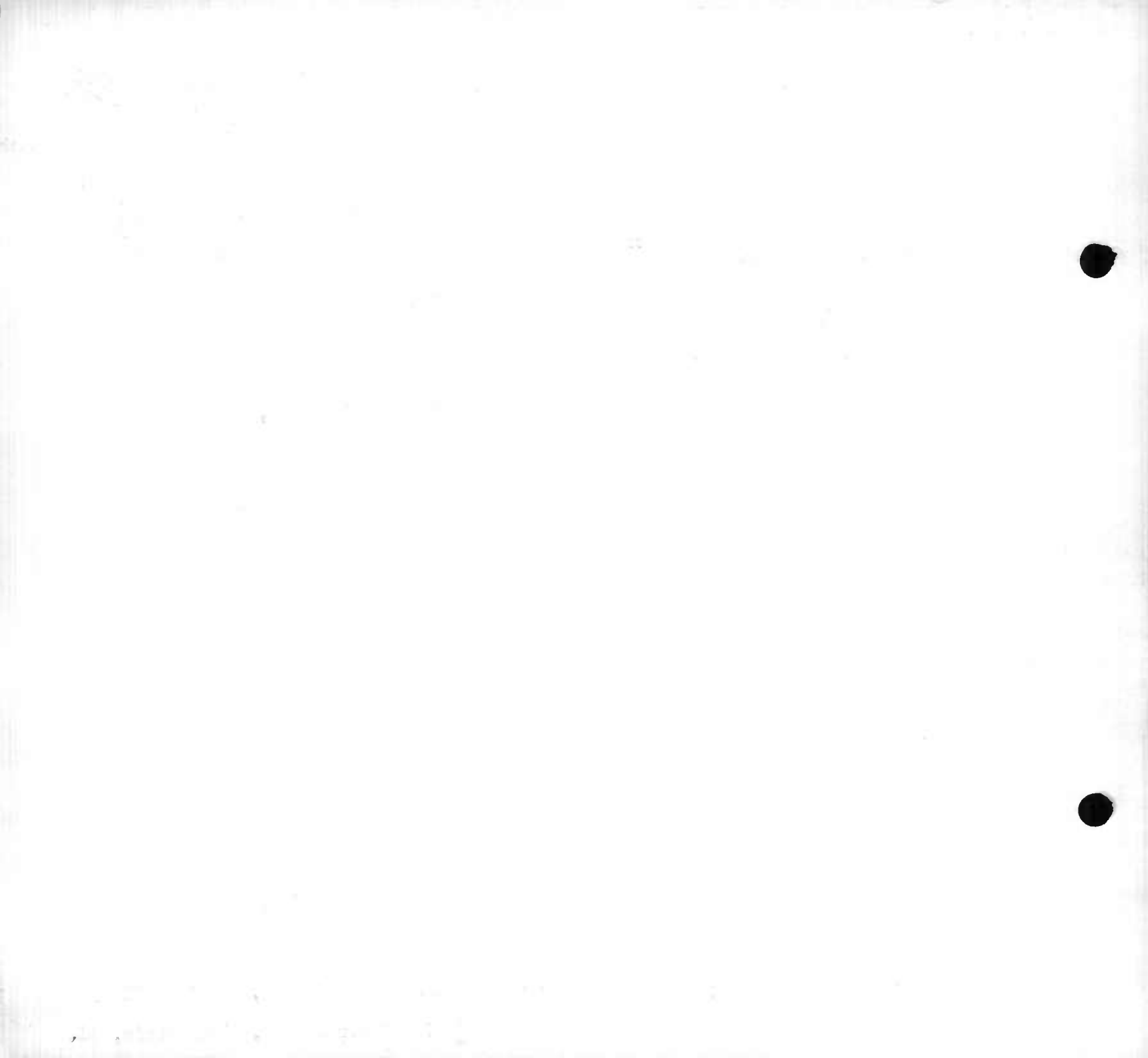
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6882	
1. NAME OF DECEASED (Type or Print) COLEMAN STEWART		2. DATE AND HOUR OF DEATH JULY 4, 1969 7:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Essex 21221		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1500 HOPWELL AVE		21221			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/13	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enameler		10B. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME PERRY STEWART			
14. MOTHER'S MAIDEN NAME ANNIE HARRIET		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII			
16. SOCIAL SECURITY NO. 253 90 7268		17. INFORMANT 4940 Eastern Avenue ADDRESS Records: Baltimore, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) standing alone UNDERLYING CONDITION lost.		(B) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1/25	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DOA July 4 19 69 to July 4 19 69 , that (I) (we) last saw the deceased alive on DOA 3 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jaime F. Casellas		23B. DATE SIGNED 7-4-69		23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS M.D.	
23D. ADDRESS 4940 Eastern Ave., Balto., Md.		23E. ADDRESS BALTIMORE MARYLAND 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR John E. Farber, M.D.		25C. FUNERAL DIRECTOR Guzdzinski Funeral Home 1407 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6883	
BIRTH NO. 69 6883		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BERNICE DICKERSON		2. DATE AND HOUR OF DEATH 7-3-69 3:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY ANN C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 702 FERNHILL RD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-20	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES TAYLOR			
14. MOTHER'S MAIDEN NAME EMMA HARRIS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT Charles Dickerson,			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive GI. bleeding 2) Anthraxis of liver 3) Esophageal varices (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-24-1969 to 7-3-1969 and that (I) (we) lost saw the deceased alive on 7-3-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Makipou		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) HOUSHANG MAKIPOU	
23D. ADDRESS		23E. MED. DIRECTOR <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 July 1969		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21225		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR W. E. Fisher, M.D.		25C. FUNERAL DIRECTOR W. E. Fisher, M.D.			
25D. ADDRESS W. E. Fisher, M.D.		25E. ADDRESS W. E. Fisher, M.D.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6884		BALTIMORE CITY HEALTH DEPARTMENT		X Registered No. 69 6884	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SMOOT, ESTELLE B		2. DATE AND HOUR OF DEATH July 5, 1969 1:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) MARYLAND BALTO. CO. BALTIMORE, LANDSDOWNE D. STREET ADDRESS (If rural, give location) 2620 FIRST AVE 21227			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/28/1915	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES E. STEWART		14. MOTHER'S MAIDEN NAME JAN STELLA BARKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 10 0237		17. INFORMANT ADDRESS Mrs Jane Cage 2620 1st Ave Balto Md	
18. 45391 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO CEREBRAL THROMBOSIS (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 1969 to July 5 1969, that (I) (we) last saw the deceased alive on July 5 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Amonrath Chittchang		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 5, 1969	
23C. PHYSICIAN'S NAME (Type) AMONRATH CHITTCHANG		23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/8/69	24C. NAME OF CEMETERY OR CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie Md A.A.Co.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR E. J. B. M.D.		25C. FUNERAL DIRECTOR McGulley F. H. 237 Potomac Ave 21225	

1944

1944-1945

1945-1946

1946-1947

1947-1948

1948-1949

1949-1950

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

1957-1958

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6885
BIRTH NO. 69 6885		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Francis Carr		2. DATE AND HOUR OF DEATH July 7, 1969 2:25 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, Baltimore 8. COUNTY 903		
FULL NAME OF HOSPITAL OR INSTITUTION 4940 Eastern Avenue Baltimore City Hospitals Baltimore, Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY For Self		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Francis Carr		14. MOTHER'S MAIDEN NAME Wilhelmina Wolfe		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 220-182765		17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD
18. 162-14-303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Squamous carcinoma of the lung with cerebral metastases 5 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic alcoholism		15 years		
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED XXXX		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) XXX		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXX		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) XXX
21D. TIME OF INJURY (APPROX.) XXXX		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? XX
22. I certify that XX (this hospital) attended the deceased from June 16, 1969 to July 7, 1969 , that (I) XX last saw the deceased alive on July 7, 1969 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (I) XX (did) (did not) view the body after death.				
23A. SIGNATURE George H. Sack, Jr. DEGREE MD				23B. DATE SIGNED July 7, 1969
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.		23D. ADDRESS 601 N. Broadway, Balto., Md., 21205 4940 Eastern Avenue Balto. Md 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/9/69	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR John J. Talley & Son Inc.

Callid. Hospital address is 3521 Old York Rd. CT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

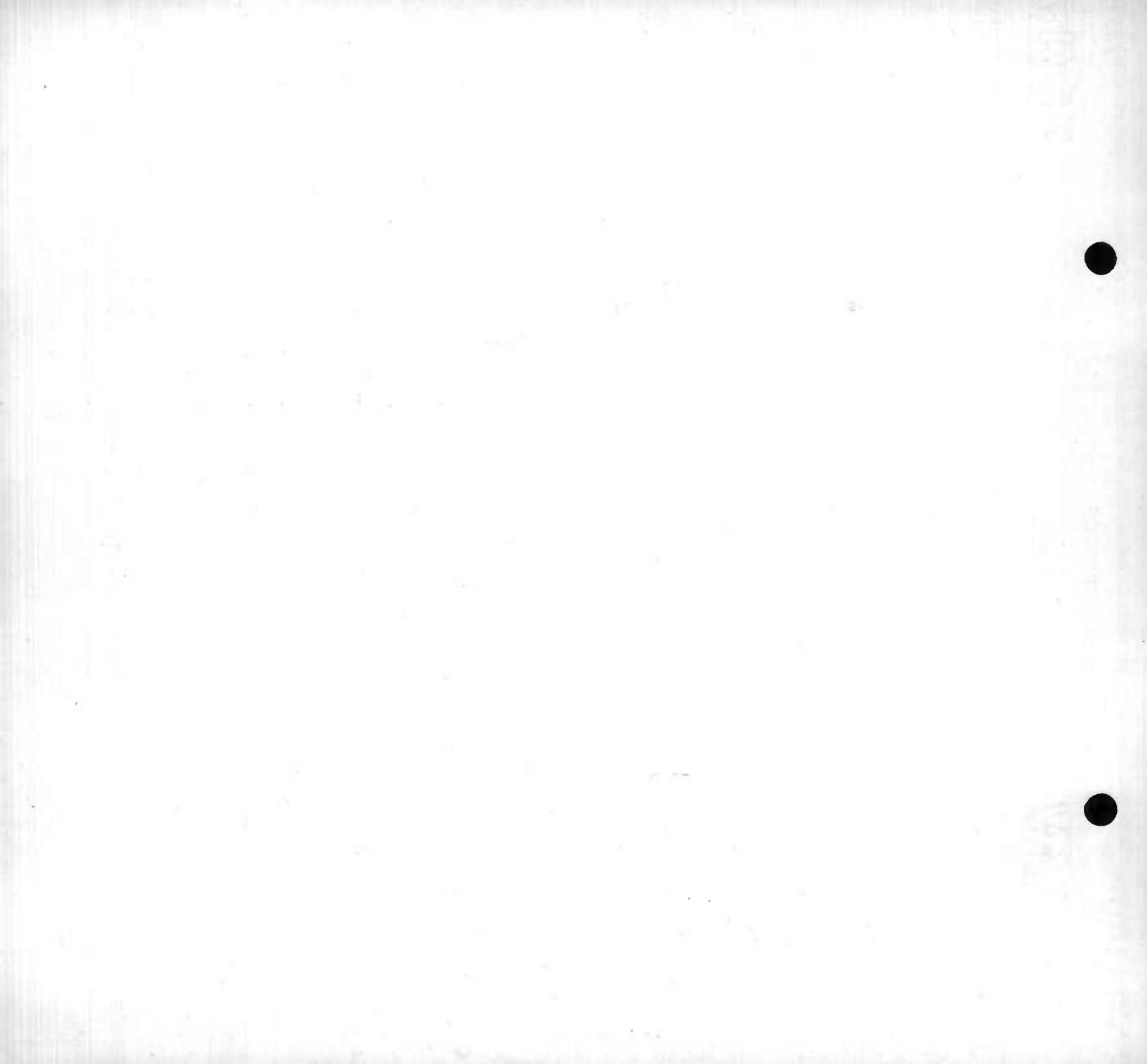
69 6886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 6886

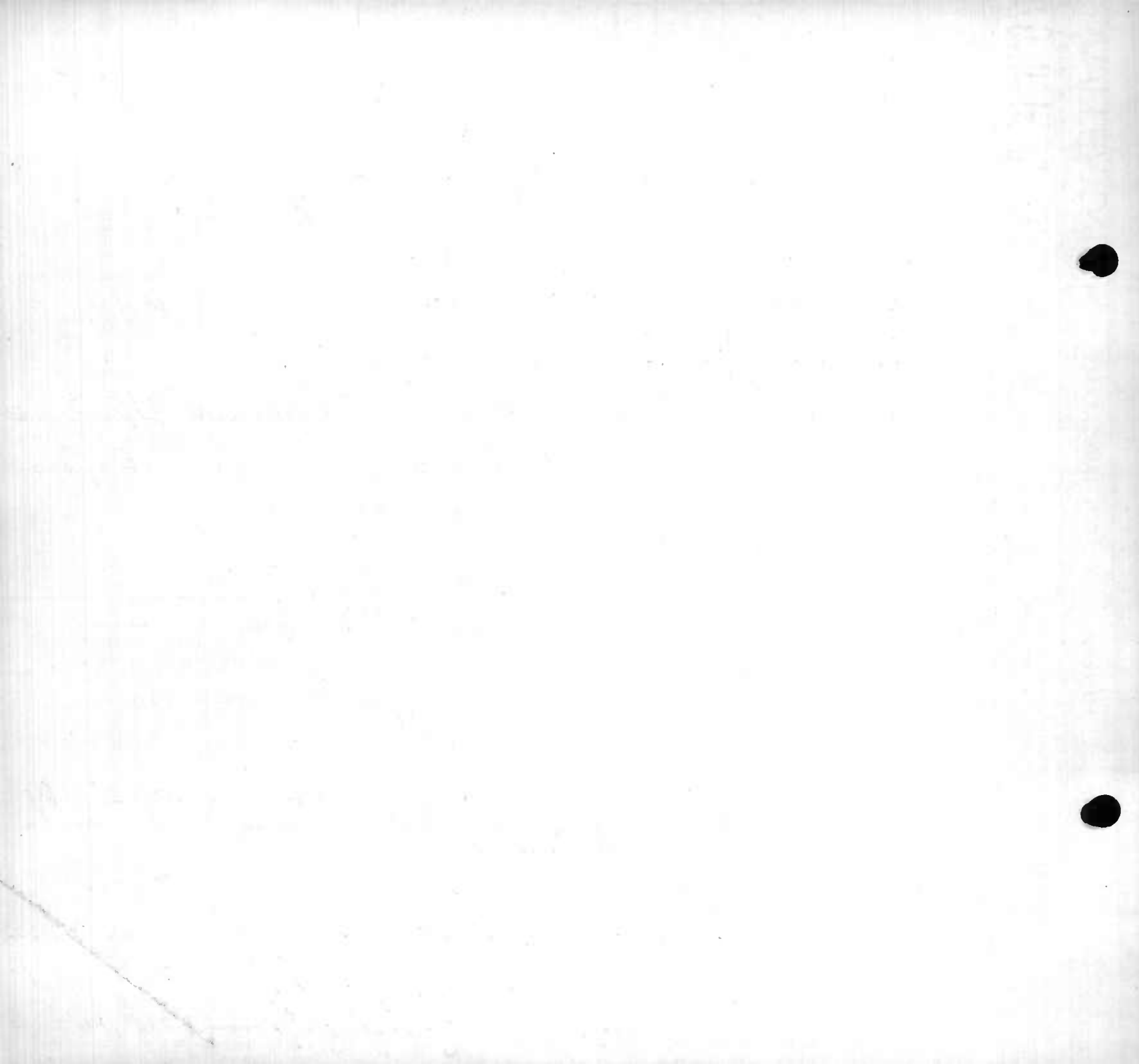
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WHITLOCK, Kathryn		2. DATE AND HOUR OF DEATH July 6, 1969 2:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & convalescent Ctr.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 401 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 11 N. Eutaw Street 21201			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-89	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Baughman		14. MOTHER'S MAIDEN NAME Cora Beiser Feeser	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-05-1794		17. INFORMANT ADDRESS Robert H. Whitlock. 1104 Wynbrook Rd. 21061	
18. 472.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Antennalitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Antennalitis		(B) DUE TO, OR AS A CONSEQUENCE OF: Antennalitis		years	
(C) Antennalitis		years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/9 19 68 to 7/6 19 69 , that (I) (we) last saw the deceased alive on 7/6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE AL MARCH				23B. DATE SIGNED 7/6/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H MARCH MD				23D. ADDRESS 2 E READ ST BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-1969		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		25D. ADDRESS 6877			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6887				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6887	
1. NAME OF DECEASED (Type or Print) <i>Gene Johnson</i>				2. DATE AND HOUR OF DEATH <i>July 3, 1969</i> <i>8:00 P.</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2607</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 613 S. Newkirk St.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>613 S. Newkirk St.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-5-1892</i>	9. AGE (in years lost birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wire Roller</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Johnson</i>				14. MOTHER'S MAIDEN NAME <i>Molly Taylor</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-01-2865</i>		17. INFORMANT <i>Mrs. Bertie Johnson</i>		ADDRESS <i>613 S. Newkirk St.</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>A-S-C-V-Disease</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>—</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>—</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>—</i>		(C) DUE TO, OR AS A CONSEQUENCE OF: <i>—</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Diabetes Mellitus</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <i>Home</i>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan - 69</i> to <i>July 3, 1969</i> , and that (I) (we) last saw the deceased alive on <i>July 3, 1969</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Melvin B. Davis M.D.</i>				23B. DATE SIGNED <i>7/5/69</i>		23C. PHYSICIAN'S NAME (Type) <i>MELVIN B. DAVIS M.D.</i>	
23D. ADDRESS <i>6800 MORNINGTON RD - DUNDALK MD 21222</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-7-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1969</i>		25B. NAME OF REGISTRAR <i>James E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Thelma Hoffmann</i>		ADDRESS <i>3218 Hudson St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

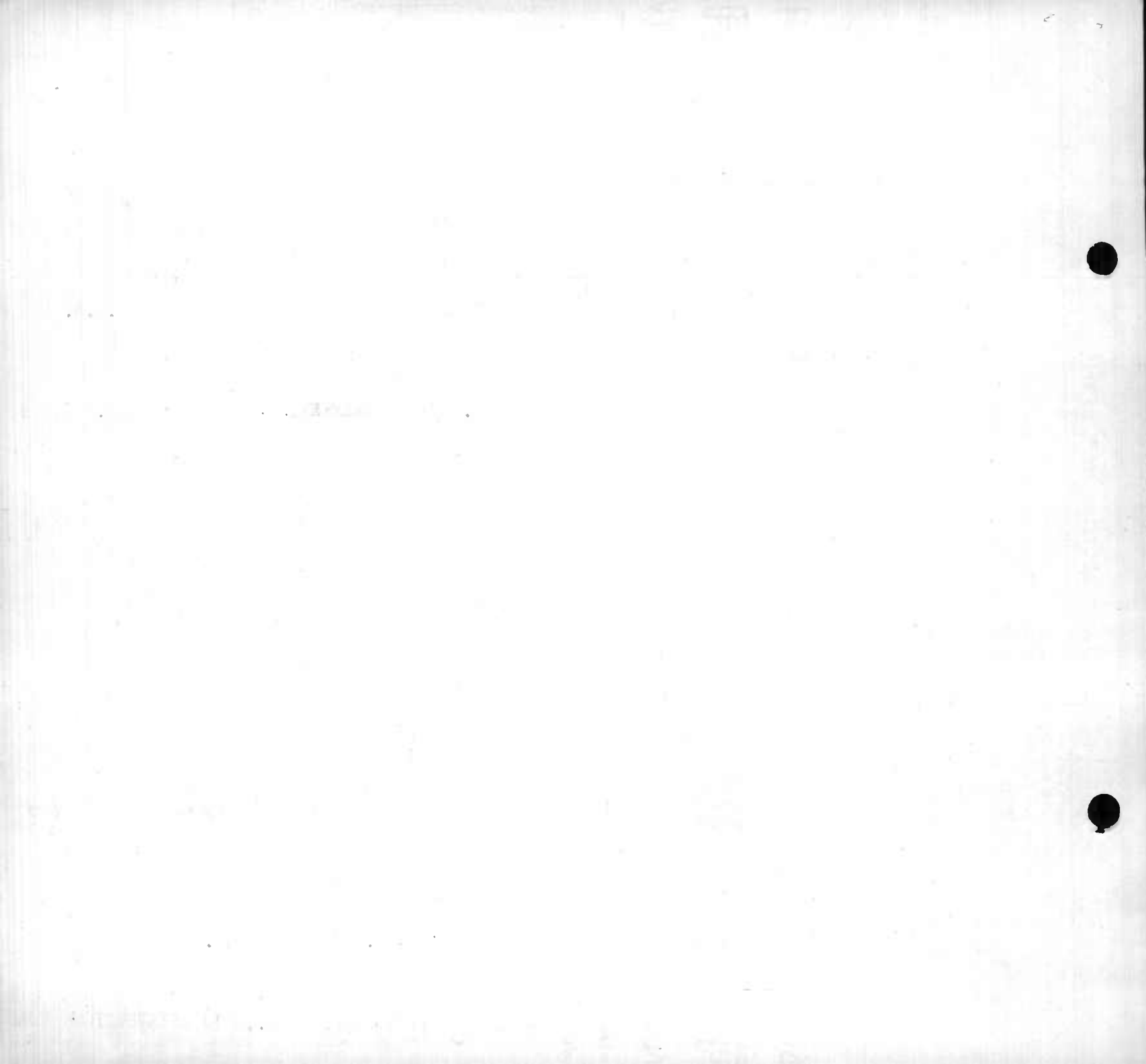
69 6888		BALTIMORE CITY HEALTH DEPARTMENT		X		69 6888	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LEOCADIA VALERIO				July 3rd 1969 4 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
SINAI HOSPITAL of BALTIMORE				Md Baltimore 5300			
42				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX				6. RACE			
Female				Cau			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11/8/18			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (in years last birthday)			
Housewife				51			
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
				Baltimore, Md			
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
George BANASHAK				U.S.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				213-01-9681			
17. INFORMANT				ADDRESS			
HUSBAND				Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				X			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/1 1969 to 7/3 1969 that (I) (we) last saw the deceased alive on 7/3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
[Signature] M.D.				7/3/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
AGUSTIN COLLADO				Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/7/69		Oaklawn Cem		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1969		[Signature] M.D.		C. E. EVANS & SON		8802 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6889	
BIRTH NO. G-626		CERTIFICATE OF DEATH X	
1. NAME OF DECEASED (Type or Print) ROSE GRESSER		2. DATE AND HOUR OF DEATH JULY 2, 1969 10:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PLEASANT MANOR NURSING HOME 90		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co. 5300 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2713 SUMMERSON ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME MAYER BEICHMAN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT GRESSER ADDRESS MR. HERMAN GRESSER, 2713 SUMMERSON RD. #21209
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Arteriosclerotic Heart Disease 47 years (C) Heart Block APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/17 19 65 to 7/2 19 69 , that (I) (we) last saw the deceased alive on 7/2 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Israel Zinberg		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG		23D. ADDRESS 4000 W. NORTHERN PKWY.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7-4-69	24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

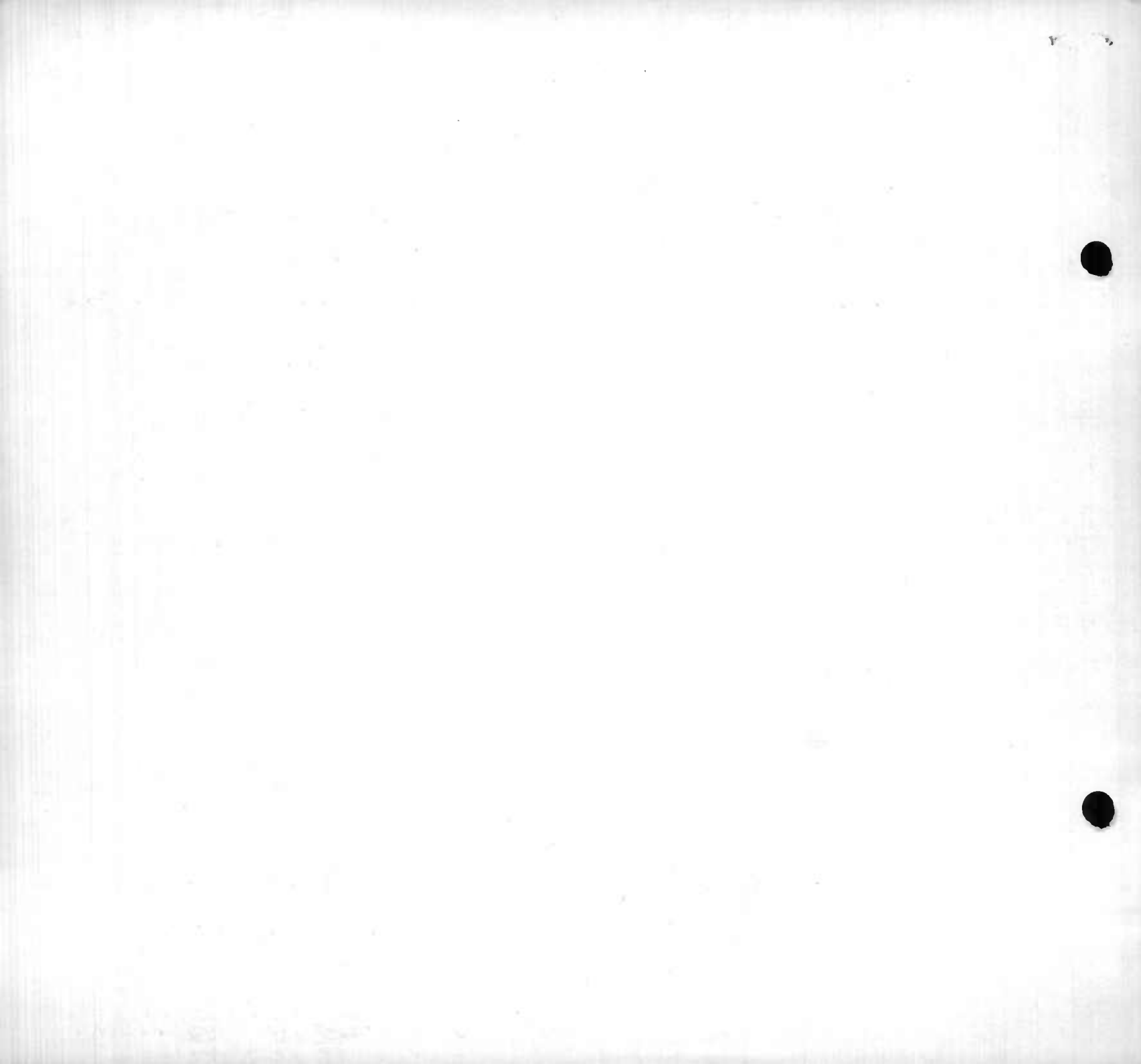
D-200		BALTIMORE CITY HEALTH DEPARTMENT		69 6890	
BIRTH NO.		69 6890		REG. NO. 69 6890	
1. NAME OF DECEASED (Type or Print) George R. Desi			2. DATE AND HOUR OF DEATH 7/2/69 18:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO. CO. C. CITY OR TOWN RANDOLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Md. Hospital 38			E. STREET AND NUMBER 9822 Tolworth circle		
5. SEX MALE	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/18	9. AGE (in years last birthday) 51	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEERING		10B. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) HUNGARY	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Morris Desi		
14. MOTHER'S MAIDEN NAME Thene xxxxxxxxxxxxxx Dec.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES U.W. II		
16. SOCIAL SECURITY NO. 112-10-5854			17. INFORMANT MRS. CAROL DESI ADDRESS 9822 TOLLWORTH CIRCLE #21133		
18. CAUSE OF DEATH 4/10/9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 0700 PM 7/2 1969 to 0845 7/2 1969 that (I) (we) last saw the deceased alive on 7/2 1969 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Ernest S. Sears, Jr., MD 23B. DATE SIGNED 7/2/69 23C. PHYSICIAN'S NAME (Type) Ernest S. Sears, Jr., MD 23D. ADDRESS UNIVERSITY HOSPITAL 24A. BURIAL CREMATION, DATE REMOVAL (Specify) BURIAL 7-4-69 24B. NAME OF CEMETERY OR CREMATORY LOUDON PARK 24C. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND 25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR SOB LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN ROAD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

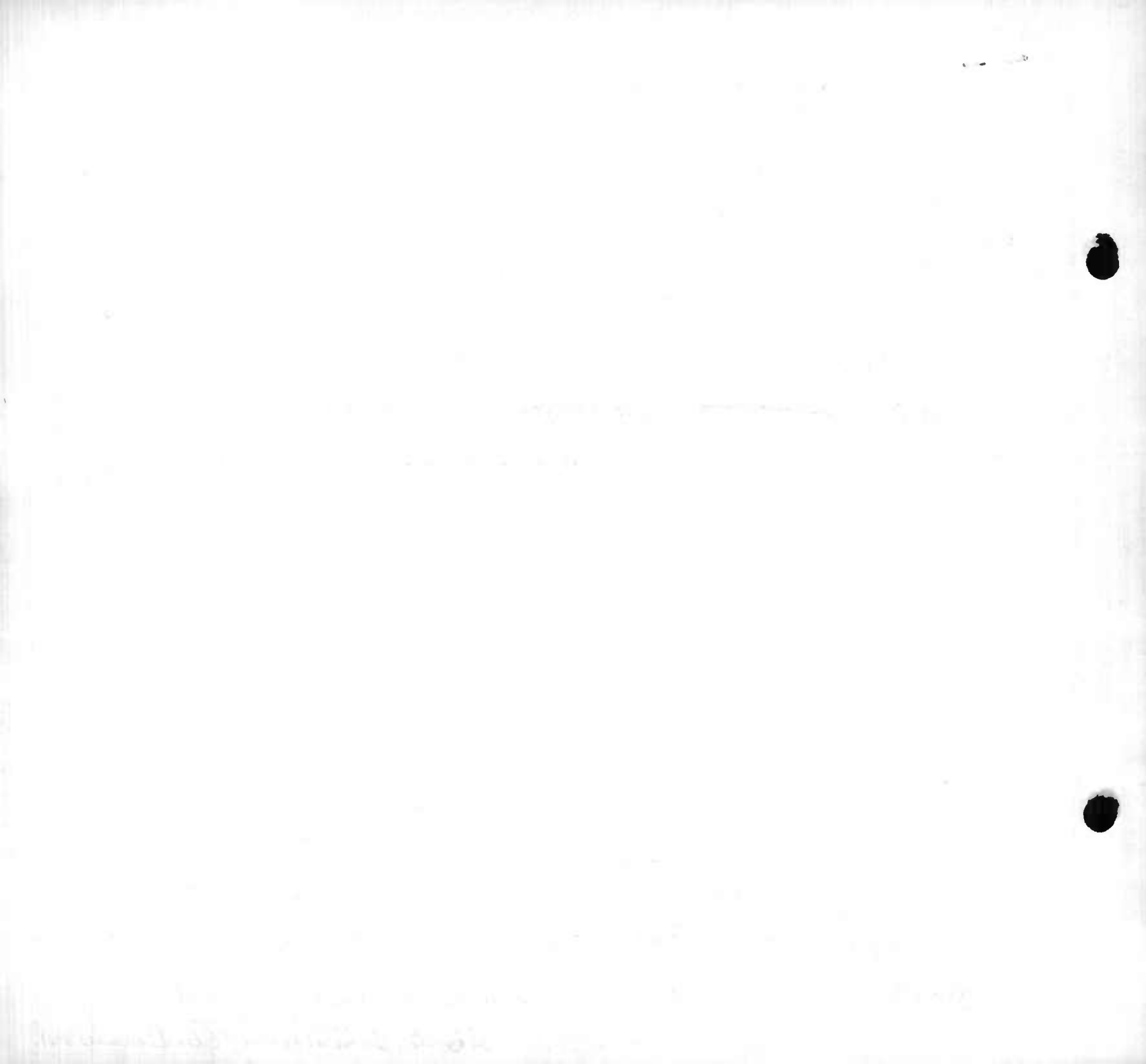
W-623 69 6891		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6891	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA Louise WRIGHT		2. DATE AND HOUR OF DEATH July 3, 1969 7:30 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital 42 Baltimore		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 113 Wyndcrest Ave	
S. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/19/1909	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Advisor		10B. KIND OF BUSINESS OR INDUSTRY Dinning Room		11. BIRTHPLACE (State or foreign country) Md 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Dulin		14. MOTHER'S MAIDEN NAME Kennard		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-01-0362		17. INFORMANT D.L. Banks		ADDRESS 113 Wyndcrest Ave - 28	
18. I 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary of Breast		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory failure (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary of Breast (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION June 24, 69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED metastatic carcinoma		20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/4 19 69 to 7/3 19 69 , that (I) (we) last saw the deceased alive on 7-3 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE hmeessen		23B. DATE SIGNED July 3, 1969		23C. PHYSICIAN'S NAME (Type) Michael MEESEN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY or CREMATORY Meadowdale Cemetery	
24D. LOCATION Belridge - Howard Co Md		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Dr. E. J. Talley, M.D.	
25C. FUNERAL DIRECTOR Earl M. Hall Jr.		25D. ADDRESS 301 Frederick Rd		25E. CITY OR TOWN Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 6892	
1. NAME OF DECEASED (Type or Print) LUCKART, GEORGE ANTHONY						2. DATE AND HOUR OF DEATH 7/4/69 12 NOON M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL						A. STATE MD.					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3001 S HANOVER ST.						B. COUNTY GEN BURNIE, AAC 5200					
						C. CITY OR TOWN ALEX BURNIE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						E. STREET AND NUMBER 101 SCHARTER ST.					
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1/24/14		9. AGE (In years last birthday) 55		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY WORKED FOR J.E. SEAGRAM SONS MD.				11. BIRTHPLACE (State or foreign country) MD.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME JOHN LUCKART				14. MOTHER'S MAIDEN NAME MGT. CAO NINON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-07-5406		17. INFORMANT PTS. CHART				ADDRESS	
18. 15-381 CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH METASTATIC CARCINOMA OF COLON											
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST											
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:											
(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C) DUE TO, OR AS A CONSEQUENCE OF:											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 7-4				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-12 19 69 to 7-4 19 69 that (I) (we) lost saw the deceased alive on 7-4 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Barry A. Blum MD								23B. DATE SIGNED 7-4-69		23C. PHYSICIAN'S NAME (Type) BARRY ALAN BLUM MD	
23D. ADDRESS SOUTH BALTIMORE GENERAL HOSP								24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69	
24C. NAME OF CEMETERY OR CREMATORY Glenn Haven Memorial Park								24D. LOCATION (City, town, or county) (State) Glenn Burnie, MD		24E. FUNERAL DIRECTOR Robert P. ...	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969								25B. NAME OF REGISTRAR ...		25C. ADDRESS ...	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				X REG. NO. 69 6893	
BIRTH NO. 69 6893					
1. NAME OF DECEASED (Type or Print) WEISS MR JOHN M		2. DATE AND HOUR OF DEATH 6/27/69 12-15 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL		A. STATE BALTO. CO.		B. COUNTY 5300	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALLO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5823 Comstock Ave (06)					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 16 19	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. C	
13. FATHER'S NAME John L. Weiss		14. MOTHER'S MAIDEN NAME Maudie Grace		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) Yes WW2		16. SOCIAL SECURITY NO.		17. INFORMANT Phyllis N. Weiss (wife)	
18. 4519 I		CAUSE OF DEATH		ADDRESS 5823 Comstock Ave (06)	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) 2 Pulmonary Embolism. ? Myocardial DUE TO, OR AS A CONSEQUENCE OF:			
(C) infarction; Shock; thrombophlebitis.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-5-1969 to 6-27-1969 that (I) (we) last saw the deceased alive on 6-27-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mesbah Ud Dowla MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/27/69	
23C. PHYSICIAN'S NAME (Type) MESBAH UD DOWLA MD		23D. ADDRESS CHURCH HOME AND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/69		24C. NAME OF CEMETERY OR CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) BALLO MD					
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR M. J. Delmonico	
				ADDRESS 6067 Hay Rd	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6894

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILHELM BECKER				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 30, 1969 5:05 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1969 5:05 p.m.			
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2734	
9. DATE OF BIRTH 6/10/30		10. AGE (In years last birthday) 39		11. BIRTH PLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Becker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewer		15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-30-1463		18. INFORMANT Henry Bremer		19. CAUSE OF DEATH E9171X		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Craniocerebral injuries				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) YES (Head)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Factory		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? National Brewery 2609			
22D. TIME OF INJURY (APPROX.) 6 30 69 3:30 p.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Door opened under pressure, hit subject in head, drove him against pipes			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 1, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify) cremation		24B. DATE 7/5/69		24C. NAME OF CEMETERY OR CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Off. Blegmann		ADDRESS 6067 Hay Rd	

James Baker

Washington

219-21-1403 Perry Avenue

June 1930
Bureau
Bureau

W/211

John Doe

Washington 7/1/31

Washington 7/1/31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-121		69 6895		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 61 1869686895	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) TABAKOF, ALLEN B.				2. DATE AND HOUR OF DEATH July 5, 1969 12:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE				5. SEX male 6. RACE white			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital 33		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT		10B. KIND OF BUSINESS OR INDUSTRY FREE STATE Products		8. DATE OF BIRTH 1-13-06		9. AGE (In years last birthday) 63		11. BIRTHPLACE (State or foreign country) Rumania	
13. FATHER'S NAME Sussman TABAKOF		14. MOTHER'S MAIDEN NAME Esther		12. CITIZEN OF WHAT COUNTRY? USA		15. Was Deceased Ever In U. S. Armed Forces? (Yes, go or unknown) (If yes, give war or dates of service) Yes WW II			
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Ada Tabakof-3109 Northbrook Rd				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, esthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO RESPIRATORY ARREST (B) MALIGNANCY, PROBABLY PRIMARY IN DUE TO, OR AS A CONSEQUENCE OF: dx Prostatic CA (C) The prostate with cerebral metastases 10 months				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2 NA		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NA			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NA		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NA		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NA		21D. TIME OF INJURY (APPROX) 1 Month 1 Day 1 Year 1 Hour NA			
21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> NA		21F. HOW DID INJURY OCCUR? NA				22. I certify that (I) (this hospital) attended the deceased from 7/5/69 to 7/5/69 that (I) (we) last saw the deceased alive on 7/5/69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John L. Sullivan, M.D.		23B. DATE SIGNED July 5, 1969		23C. PHYSICIAN'S NAME (Type) JOHN L. SULLIVAN M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 6/69		24C. NAME OF CEMETERY or CREMATORY Ches Schalom		24D. LOCATION Prestertown, Md.		24E. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR James E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sol Berman & Sons Inc.		ADDRESS 6000 Rust. Road			

1871

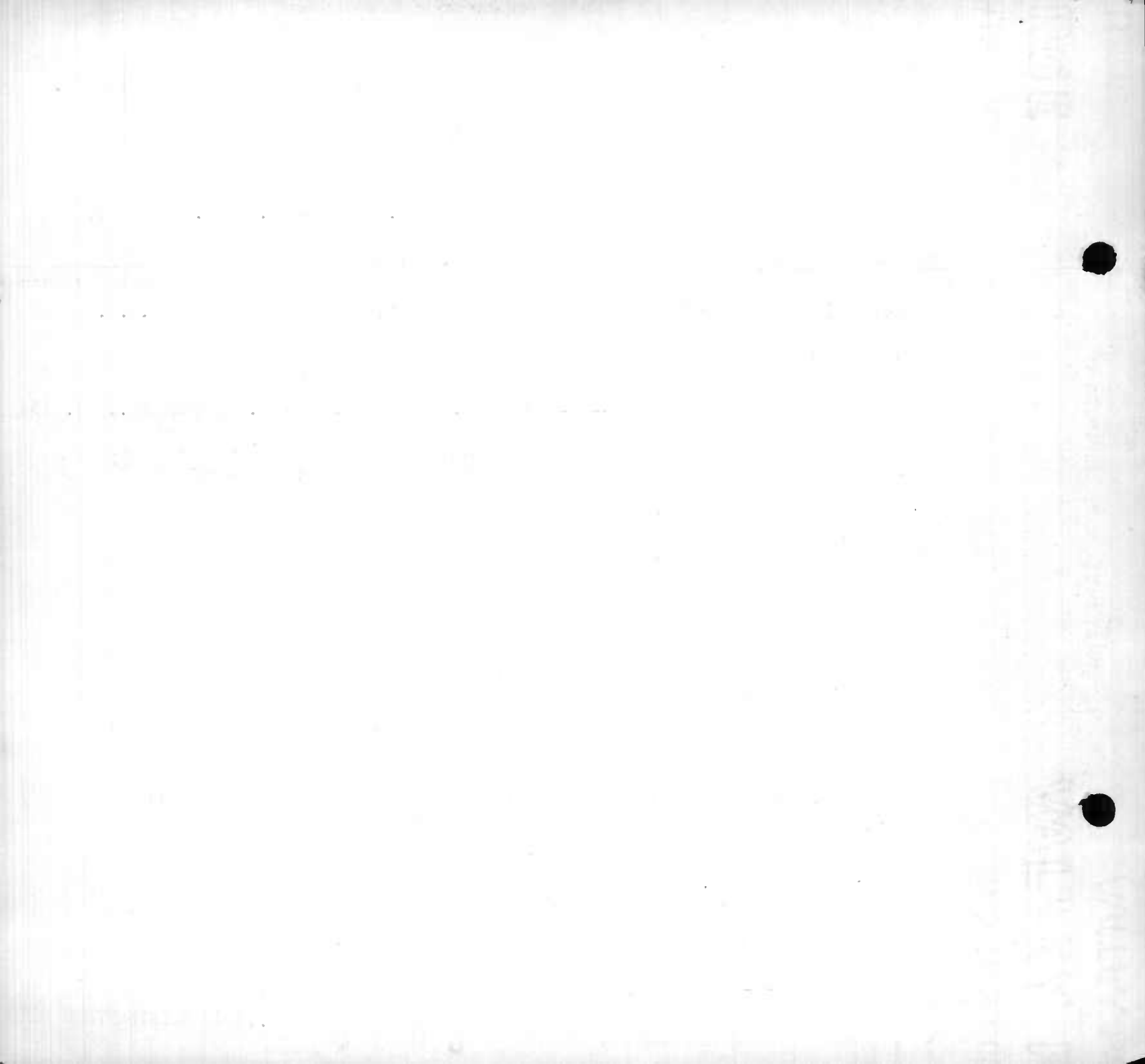
THE STATE OF NEW YORK
IN SENATE
JANUARY 1871

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1870

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

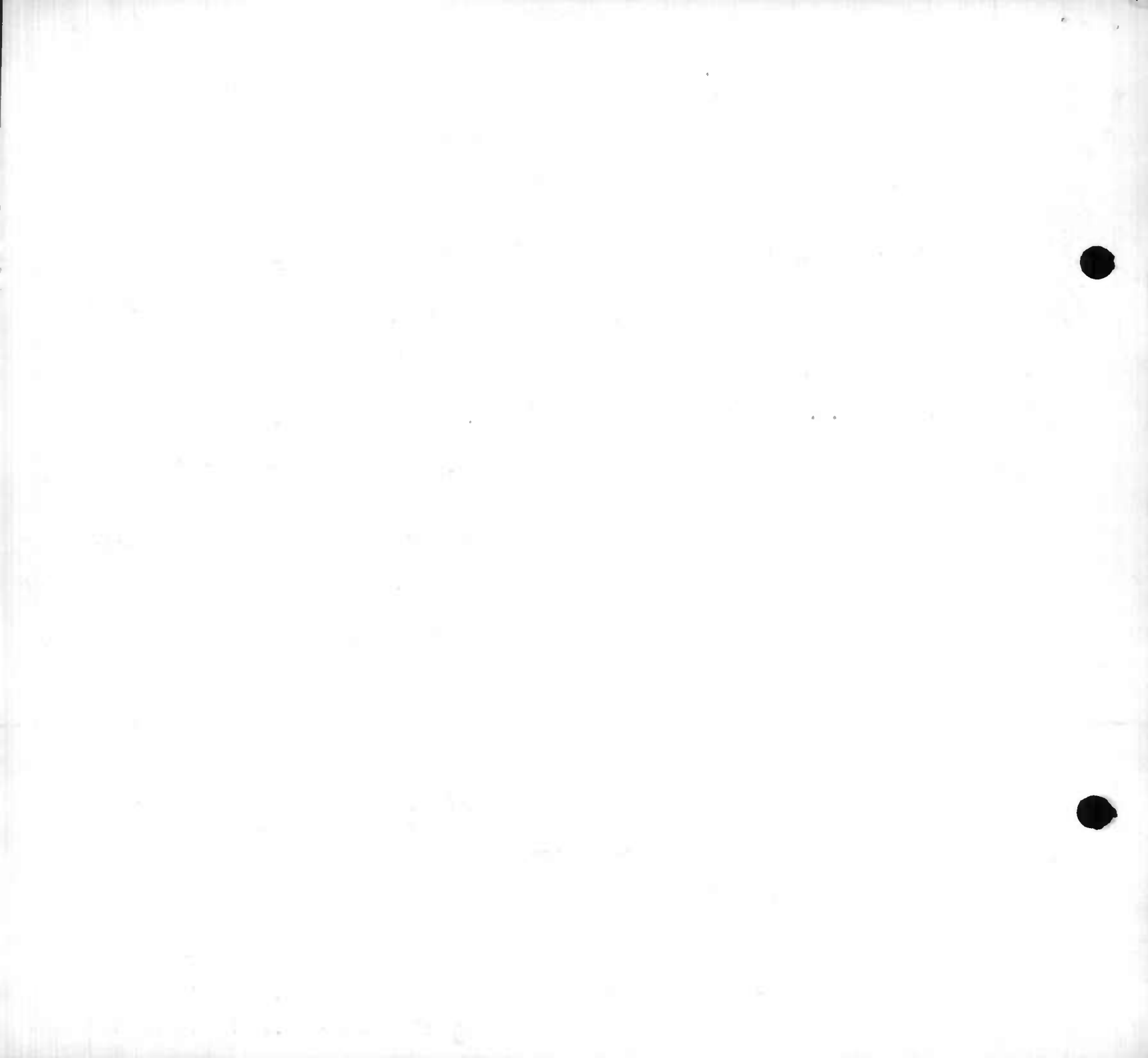
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6896	
<div style="display: flex; justify-content: space-between;"> W-560 69 6896 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) SAMUEL WINER			2. DATE AND HOUR OF DEATH JULY 7, 1969 2:40 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1201		
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL 37			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3900 N. CHARLES ST., APT. 1301 #18		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1902	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JACOB WINER		
14. MOTHER'S MAIDEN NAME EVA COHEN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219-10-9045			17. INFORMANT ADDRESS MRS. IDA WINER, 3900 N. CHARLES ST., APT. 1301		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.31 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH inter-sclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from AUGUST 9 1950 to JULY 7 1969 , that (I) (we) last saw the deceased alive on JUNE 11 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph DB King			23B. DATE SIGNED 7-8-69		
23C. PHYSICIAN'S NAME (Type) JOSEPH KING			23D. ADDRESS 2 HAMILL ROAD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-8-69		24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV	
24D. LOCATION BALTIMORE, MARYLAND		24E. NAME OF REGISTRAR SOL LEVINSON & BROS.			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR SOL LEVINSON & BROS.		25C. FUNERAL DIRECTOR ADDRESS 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

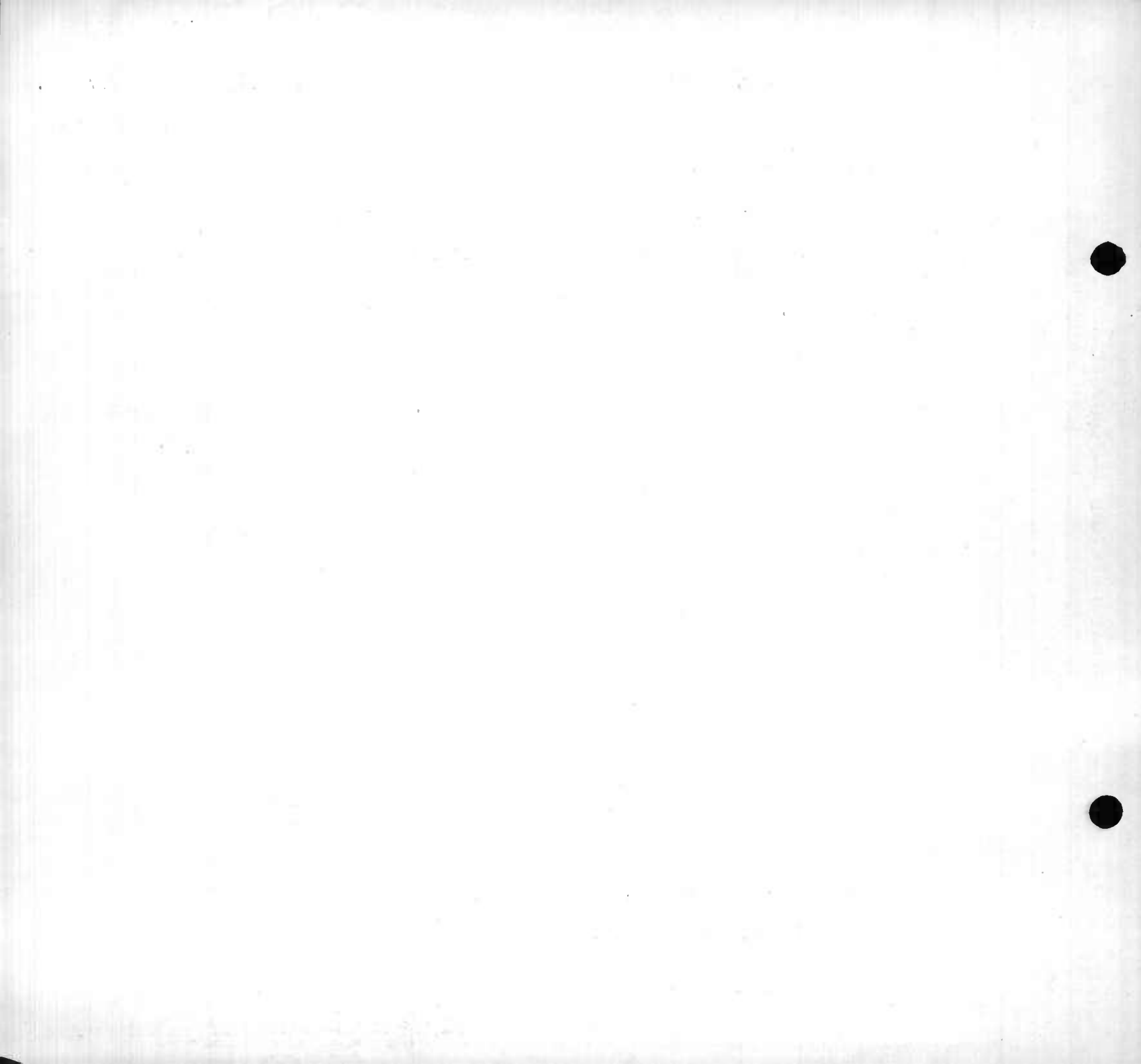
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-456 69 6897		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6897	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MORRIS TELLEM		2. DATE AND HOUR OF DEATH July 5, 1969 6:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of BALTIMORE 42			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balto. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3332 Dolfield Ave 21215		
5. SEX Male	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/00	9. AGE (in years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATE		10B. KIND OF BUSINESS OR INDUSTRY EMPLOYEE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME Jacob TELLEM			14. MOTHER'S MAIDEN NAME Fanny FINKELSTEIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		16. SOCIAL SECURITY NO. 212-09-2196		17. INFORMANT Sister MRS. SYLVIA WEINGROFF, 3231 SOUTHGREEN ROAD	
18. 43371 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident		50-60 hrs
			(B) Cerebral embolism DUE TO, OR AS A CONSEQUENCE OF:		50-60 hrs
			(C) Arteriosclerosis		Several years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Myocardial Infarction		10 years
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 2nd 1969 to July 5th 1969 that (I) (we) last saw the deceased alive on July 5th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 7/5/69	
23C. PHYSICIAN'S NAME (Type) AGUSTIN COLLADO				23D. ADDRESS Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-7-69		24C. NAME OF CEMETERY or CREMATORY SHAAREI TFILOH	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6898	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) James E. Tuttle		2. DATE AND HOUR OF DEATH July 7, 1969 10:45 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		8. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium 6116 Belair Road		A. STATE Maryland		B. CITY OR TOWN Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Perry Hall		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 8500 Vollmert Avenue		5. SEX Male		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-91		9. AGE (In years lost birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Suprv.		10B. KIND OF BUSINESS OR INDUSTRY Continental Can		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 03 4121		17. INFORMANT James D. Tuttle	
ADDRESS 8500 Vollmert Avenue		18. 43691 CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Advanced Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm. A. Rodgers, M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William A. Rodgers, M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-69		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969			
25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR Philip E. Chach		ADDRESS 1211 Chesaco Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6899	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Roger STOCKSDALE SR.</i>		2. DATE AND HOUR OF DEATH <i>7/4/69 1:00 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALTIMORE CO.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Lutherville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baltimore City Police Dept.</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>12-14-06</i> 9. AGE (In years last birthday) <i>63</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Harry STOCKSDALE</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Oliver</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-105697</i>		17. INFORMANT <i>DOROTHY S. STOCKSDALE</i> ADDRESS <i>SAME</i>	
18. <i>394.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary infarction</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Initial in sufficiency</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>old endocarditis.</i> (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/25/69</i> 19 to <i>7/4/69</i> 19, that (I) (we) last saw the deceased alive on <i>7/4/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/4/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARION FRIEDMAN MD</i>		23D. ADDRESS <i>5211 Hartford Rd Baltimore, MD 21214</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/8/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Dulany Valley Memorial Park Baltimore</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. (State) <i>MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1969</i>		25B. NAME OF REGISTRAR <i>James E. Talbot, M.D.</i>		25C. FUNERAL DIRECTOR <i>Paul E. Chencoweth JR 3615 Chestnut Ave</i>	

812-10-5217 Dorothy & Leonard 24 75

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
69 6900				69 6900		69 6900	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				<i>Madeline Wilhelmina Willett</i>		<i>July 6, 1969</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
<i>Long Green Nursing Home</i>				<i>Maryland</i>		<i>Baltimore</i>	
<i>Melrose and Bellona Aves.</i>				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				<i>Idlewyld</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				<i>6514 Maplewood Avenue</i>			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	If Under 1 Yr. Months Days	
<i>Female</i>	<i>White</i>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>Sept. 23, 1907</i>		<i>61</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>			<i>Own Home</i>		<i>Maryland</i>		<i>USA</i>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John E. Owens</i>				<i>Wilhelmina Nuensinger</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
<i>No</i>			<i>None</i>		<i>Family records</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
<i>4319 I</i>				<i>Cerebral Hemorrhage - 36 hrs</i>			
ANTECEDENT CAUSES				<i>Cerebral Arteriosclerosis - 10 y</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C).....			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1 Oct 1962</i> to <i>6 July 1969</i> , that (I) (we) last saw the deceased alive on <i>July 4</i> 19 <i>69</i> and that in (my) <i>last</i> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
<i>Charles F. Brown</i>						<i>7/7/69</i>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>July 8, 1969</i>		<i>Prospect Hill Cemetery</i>		<i>Towson, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<i>JUL 8 1969</i>		<i>Wm E. J. Brown, M.D.</i>		<i>John Burns' Sons</i>		<i>Towson, Maryland</i>	

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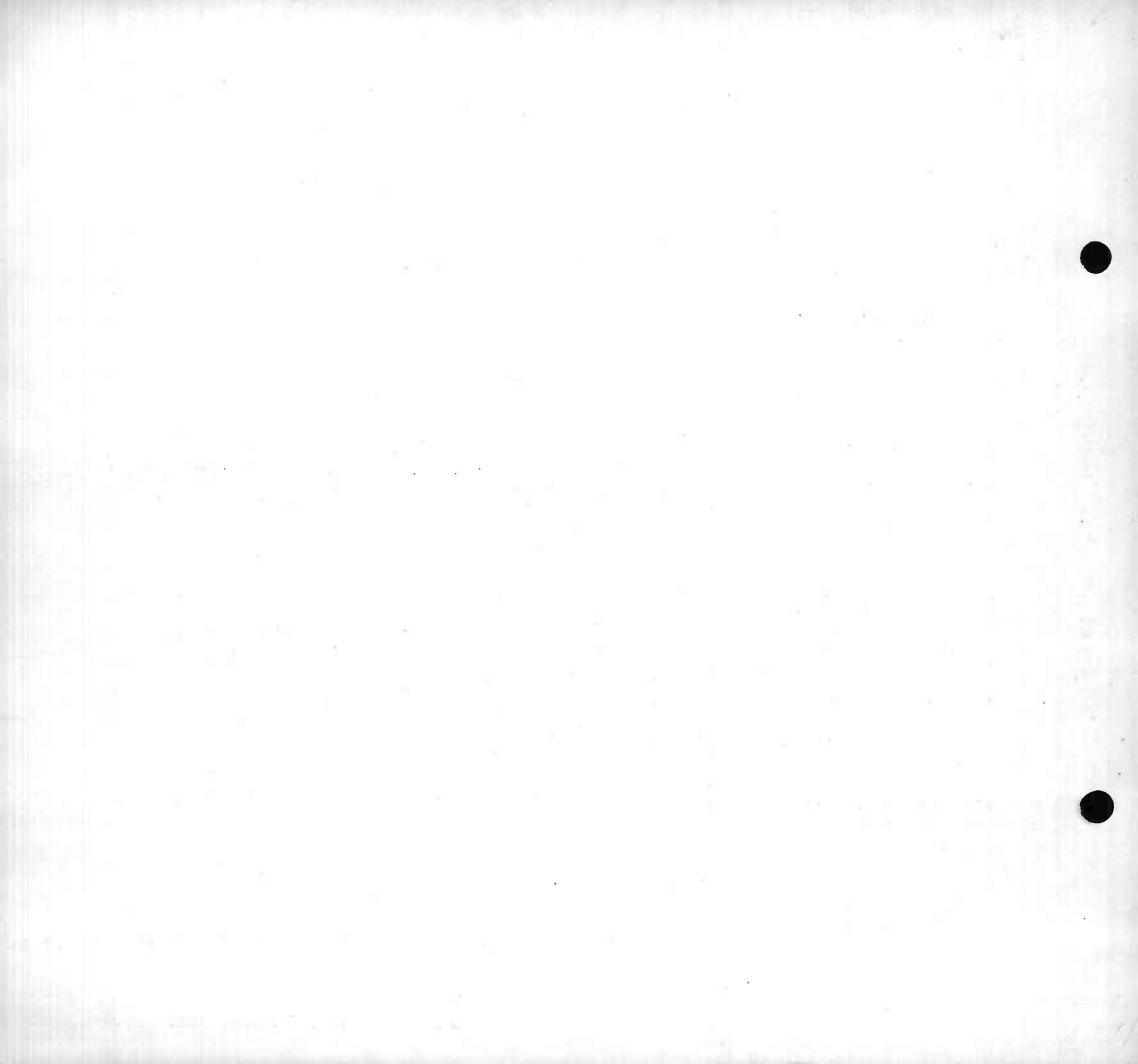
10. 1. 1900

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6901	
BIRTH NO. 69 6901		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>McC Henry Emma</i>		2. DATE AND HOUR OF DEATH <i>6-30-69 8:15 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Harbor View N.C.</i> <i>1213 Light St.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>124 Greenridge Road</i>			
5. SEX <i>Female</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-3-77</i>	9. AGE (In years last birthday) <i>92</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>5-99.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Urinary Tract Infection 4 Days</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Arteriosclerotic Cardiovascular Disease</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (at) <i>(in)</i> this hospital, attended the deceased from <i>4/29/69</i> to <i>June 30 1969</i> , that (s) <i>(we)</i> last saw the deceased alive on <i>June 30 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>A.C. Alvarez, M.D.</i>		23B. DATE SIGNED <i>July 1, 1969</i>		23C. PHYSICIAN'S NAME (Type) <i>A.C. ALVAREZ, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/69</i>		24C. NAME of CEMETERY or CREMATORY <i>Dulaney Valley Mem. Gardens</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. ADDRESS <i>Md.</i>		24F. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1969</i>	
25A. NAME OF REGISTRAR <i>James E. Barber, M.D.</i>		25B. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson, Inc.</i>		25C. ADDRESS <i>Towson, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6902
BIRTH NO. 69 6902				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) Walter Sherman Hughes Demines		2. DATE AND HOUR OF DEATH June 22, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Essex		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 32 Back River Road		
5. SEX Male	6. RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1907	9. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Demines		14. MOTHER'S MAIDEN NAME Clementine Demines		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War #2		16. SOCIAL SECURITY NO. 212-803-1139		17. INFORMANT Hattie Lou Demines
18. 392.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction		
		(B) Chronic Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF: 2 mos		
		(C) Chronic Rheumatic Endocarditis ?		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Dr. Geo. M. Baumgardner</i>		23B. DATE SIGNED 7/5/69		23C. PHYSICIAN'S NAME (Type) Dr. Geo. M. Baumgardner
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-24-69		24C. NAME of CEMETERY or CREMATORY Balto. National Cemetery
24D. LOCATION 5501 Frederick Ave.		24E. ADDRESS 8552 Philadelphia Rd., Baltimore, Md. 21206		
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Cubert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Milton E. Ellickson, 1129 N. Caroline

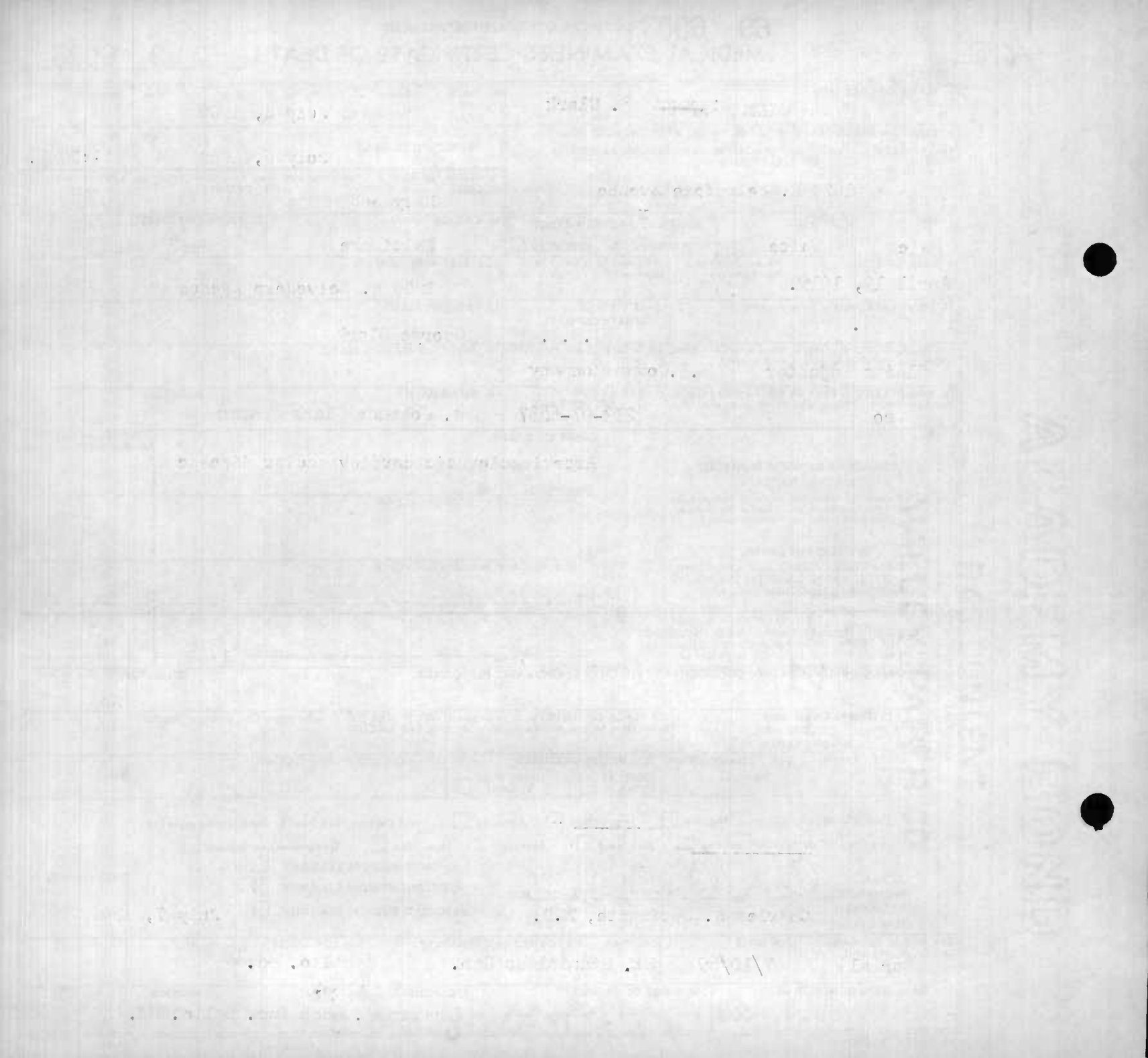
10/17

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6903

BIRTH NO.

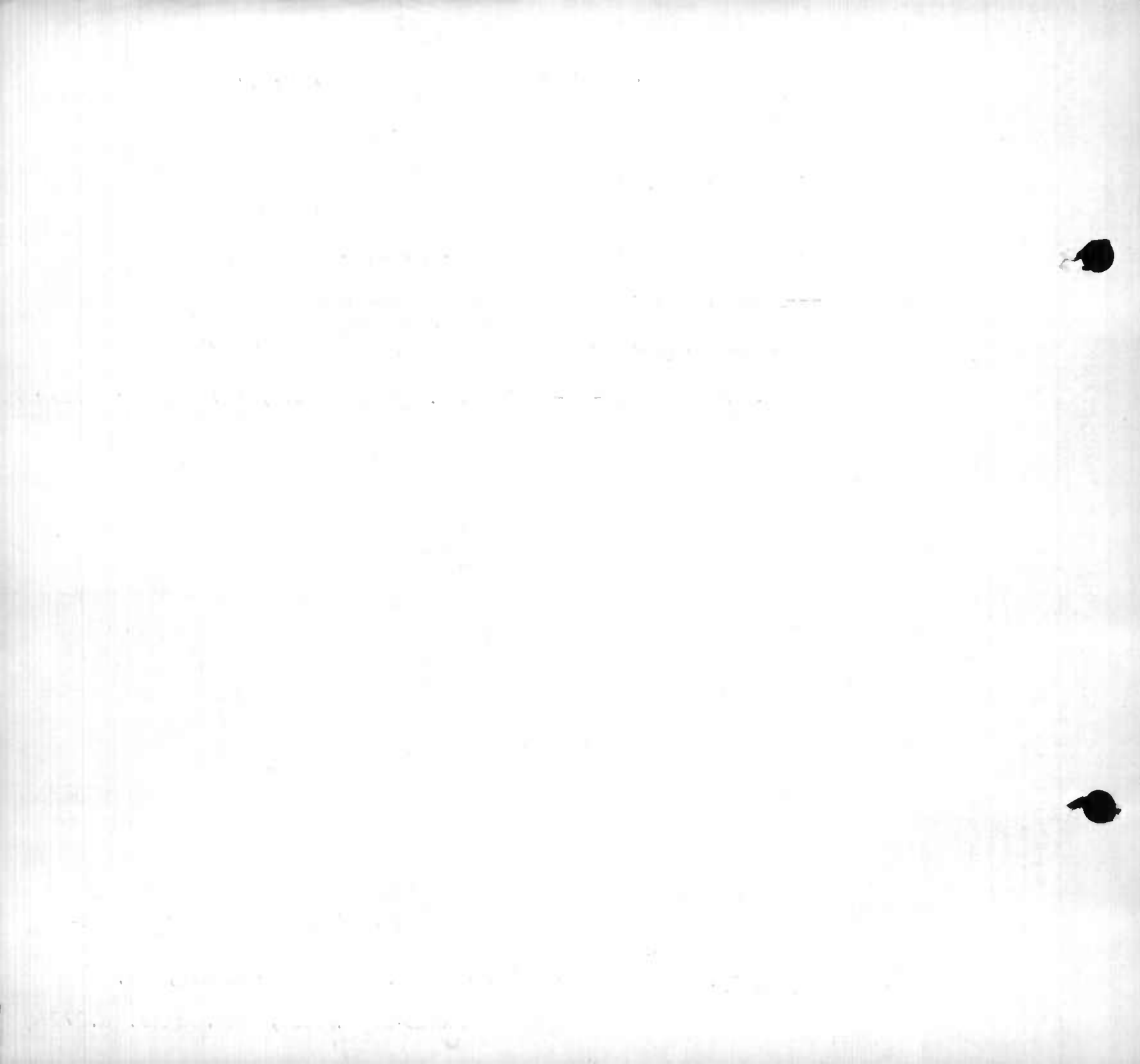
1. NAME OF DECEASED (Type or Print) WILBUR WILLIAM F. Clark		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 6, 1969	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1820 E. Belvedere Avenue		3. DATE PRONOUNCED DEAD Month Day Year July 6, 1969 11:20 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2758	
9. DATE OF BIRTH April 19, 1919.		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claims Adjuster		14B. KIND OF BUSINESS OR INDUSTRY W.T. Cowan Company	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 213-07-6487	
18. INFORMANT Mrs. Johanna Clark		ADDRESS same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 7/10/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) Month Day Year Hour July 6, 1969	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 7, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/69	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Talbot, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6904
BIRTH NO. 69 6904		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Charles J. Taylor</i>		2. DATE AND HOUR OF DEATH <i>July 6, 1969</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>Edgewood Nursing Home</i> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>5300</i>		
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 17, 1891</i>		9. AGE (In years last birthday) <i>77</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman---Florist Supplies</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Florist Supplies</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Michael Taylor</i>		
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i>		
16. SOCIAL SECURITY NO. <i>144-03-0642A</i>		17. INFORMANT <i>Mrs. Evelyn Turc, 4301 Valley View Ave</i>		
18. <i>43191</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CEREBRAL HEMORRHAGE SUDDEN</i> (B) <i>ARTERIO SCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF: <i>10 YRS</i> (C) _____		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>3/26</i> <i>1968</i> to <i>7/6</i> <i>1969</i> , that (I) (we) last saw the deceased alive on <i>7/6</i> <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Robert E. Taylor, M.D.</i>		23B. DATE SIGNED <i>7/8/69</i>		23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS <i>8100 HARFORD RD. BALTO. MD.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		
24B. DATE <i>7/9/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6905

BIRTH NO. 69 6905		69 6905	
1. NAME OF DECEASED (Type or Print) BABY BOY GADDY		2. DATE AND HOUR OF DEATH 7-6-69 6:18 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21205		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 802 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1609 N. PATTERSON PARK AVE	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 3 Days 11. BIRTHPLACE (State or foreign country) Baltimore Md 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES GADDY		14. MOTHER'S MAIDEN NAME BARBARA HENLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) M		16. SOCIAL SECURITY NO.	
17. INFORMANT James Gaddy Senior		ADDRESS	
18. 74691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST & respiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: congenital cardiac anomalies (C) unknown factors APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours			
19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
22. I certify that (I) (this hospital) attended the deceased from 7/6 19 69 to 7/6 19 69 that (I) (we) last saw the deceased alive on 7/6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David Valle M.D.		23B. DATE SIGNED 7/6/69	
23C. PHYSICIAN'S NAME (Type) DAVID VALLE M.D.		23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-69	
24C. NAME OF CEMETERY OR CREMATORY Mt Airy Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	
25C. FUNERAL DIRECTOR Charles Patterson		ADDRESS 1000 B... ..	

10/27

John & Mary Smith

10/27 - 10/28 1894

10/28

10/29

10/30/94

X

X

(10/31/94)

10/31/94

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600

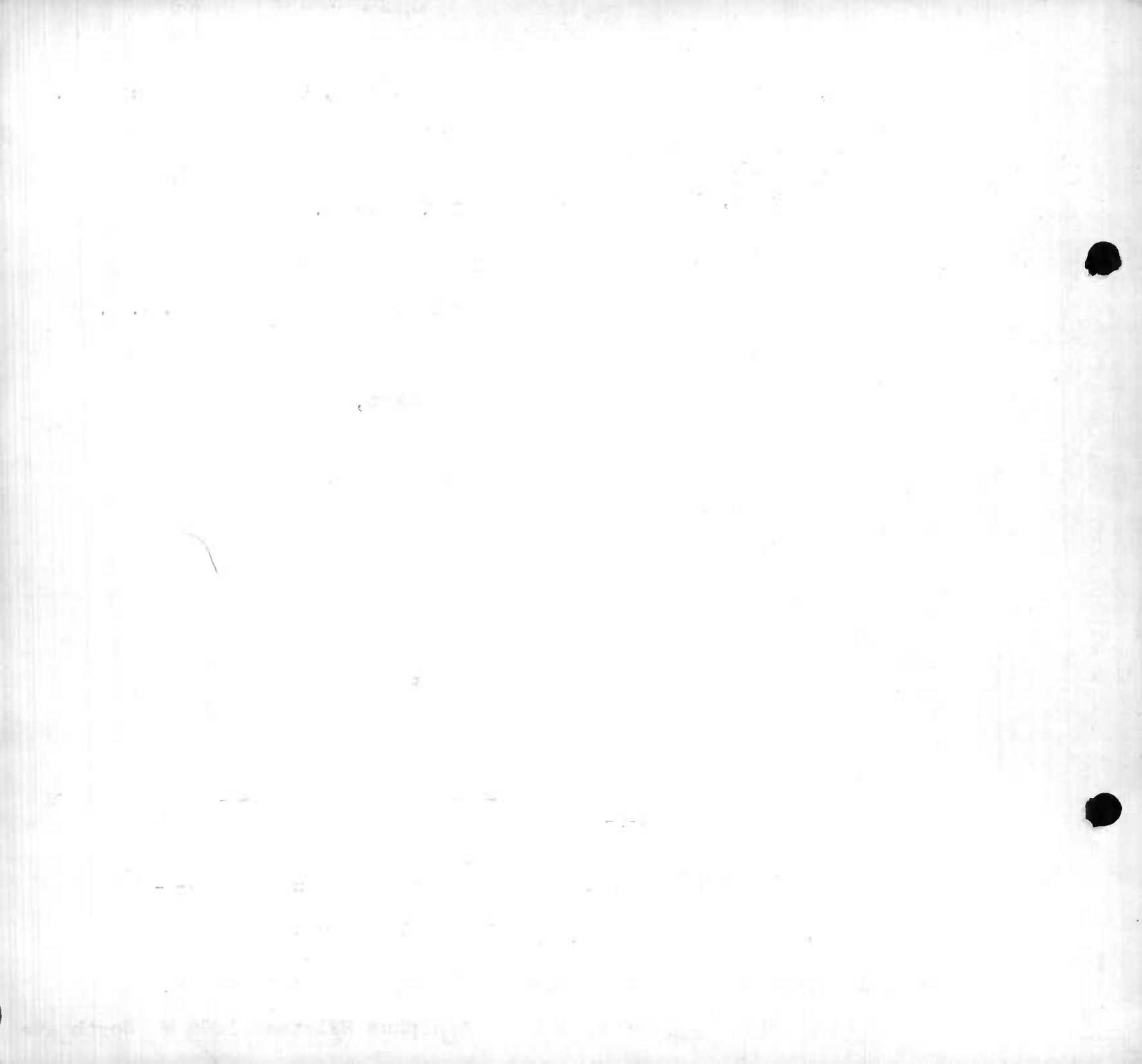
BALTIMORE CITY HEALTH DEPARTMENT				69 6906	
CERTIFICATE OF DEATH				REG. NO. 69 6906	
BIRTH NO. 69 6906		1. NAME OF DECEASED (Type or Print) BERTHA MOORE			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 7/5/69 5:50 pm M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore 42		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1601		C. CITY OR TOWN 1601	
5. SEX F 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18, 1899 9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.	
13. FATHER'S NAME George Hyson		14. MOTHER'S MAIDEN NAME Marial Keyes		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give word or dates of service) No		16. SOCIAL SECURITY NO. 214-03-0364		17. INFORMANT EULA Dawson ADDRESS 712 E. 5th Place Chicago, Ill.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Hepatitis -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Abdominal aortic aneurysm - ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: Cirrhosis - Fat liver -			
19A. DATE OF OPERATION 7/1/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal aneurysm.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1/68 19 69 to 7/5/69 19 69 that (I) (we) last saw the deceased alive on 7/5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Sagbini MD		23B. DATE SIGNED 7/5/69		23C. PHYSICIAN'S NAME (Type) JOSE SAGBINI MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-69		24C. NAME OF CEMETERY OR CREMATORY MT. Auburn Cem.	
24D. LOCATION (City, town, or county) Baltimore		24E. NAME OF REGISTRAR Robert E. Taylor, M.D.		24F. FUNERAL DIRECTOR W. L. Wilson ADDRESS 1000 Brantley Ave.	



FUNERAL DIRECTOR: IMPORTANT

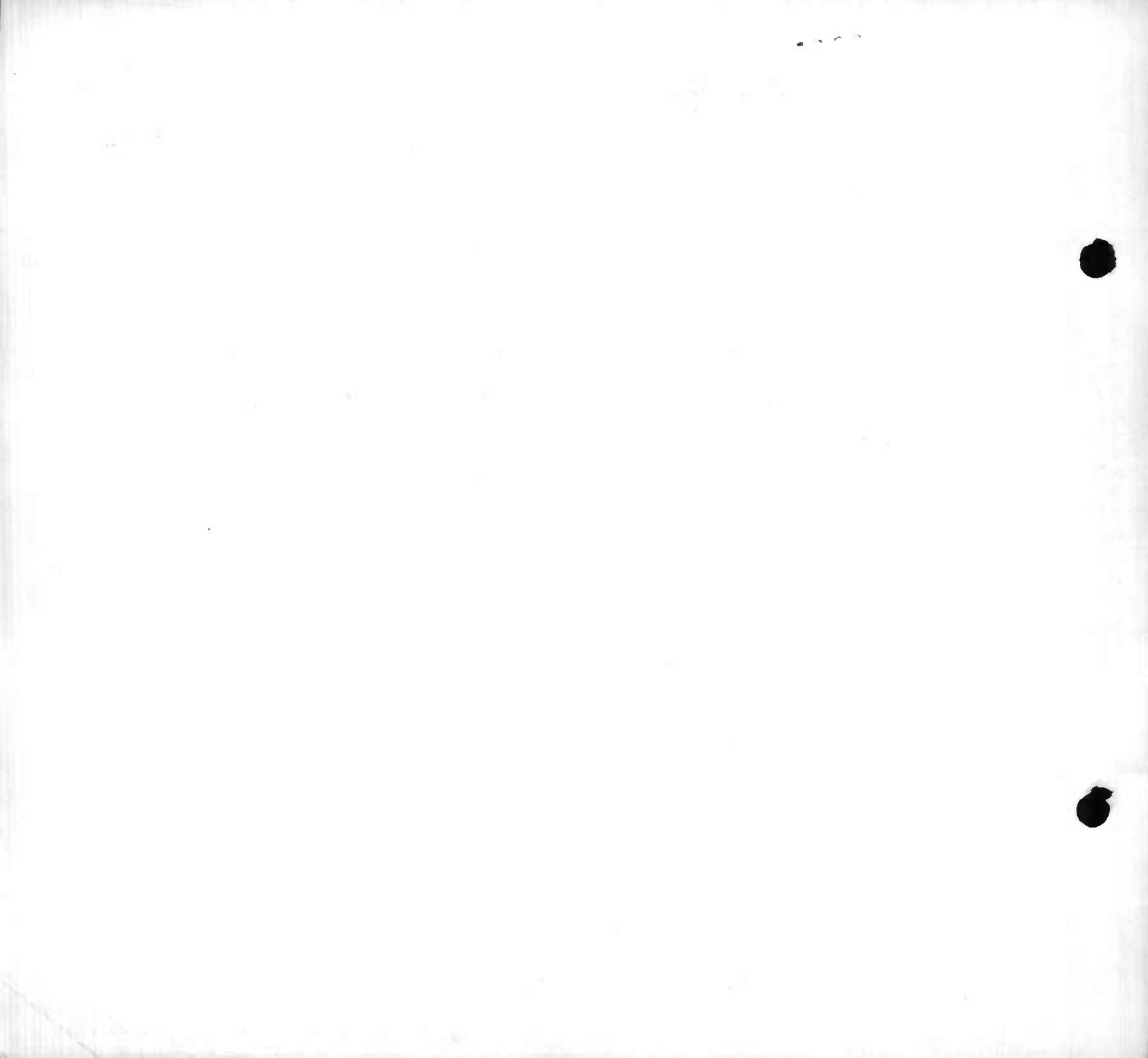
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
69 6907					REG. NO. 69 6907					
BIRTH NO.					1. NAME OF DECEASED (Type or Print)					
					2. DATE AND HOUR OF DEATH July 3, 1969 9:10 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Divison Street Baltimore, Maryland 21217					A. STATE Maryland B. COUNTY Baltimore E. STREET AND NUMBER 611 N. Baker St.					
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1900		9. AGE (In years last birthday) 69		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. ?		17. INFORMANT Chart, ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal failure (B) DUE TO, OR AS A CONSEQUENCE OF: Uremia (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 6-23-19 69 to 7-3-19 69, that (I) (we) lost saw the deceased alive on 7-3-19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE C. Tengco					23B. DATE SIGNED 7-3-69			23C. PHYSICIAN'S NAME (Type) C. Tengco M. D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

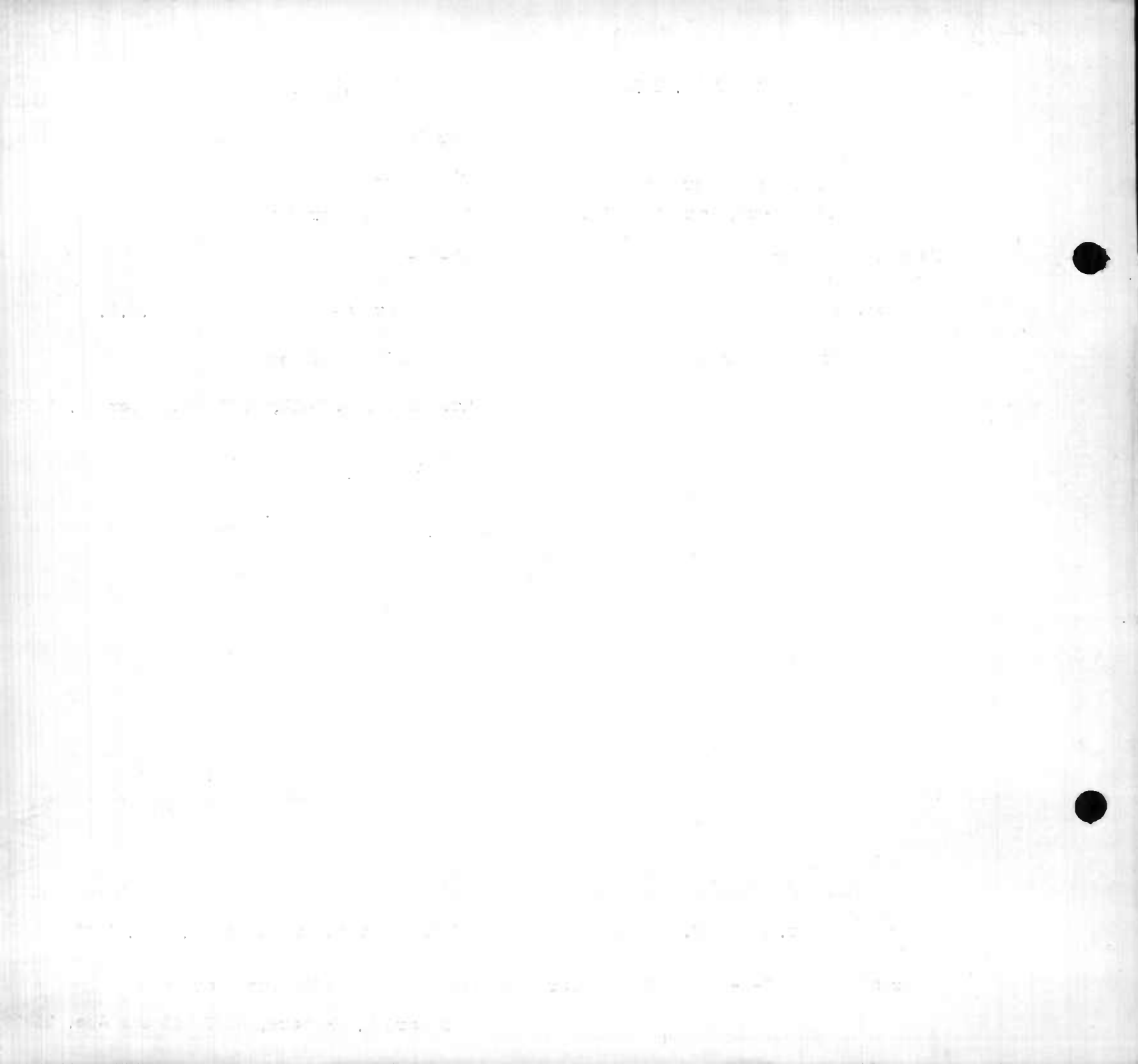
69 6908		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6908 4	
BIRTH NO. 69-11505		BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) <u>BABY BOY COPPINGER</u>		2. DATE AND HOUR OF DEATH <u>7/2/69</u> <u>9:00 P M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO. CO</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1530 LANGFORD RD.</u>			
5. SEX <u>♂</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/2/69</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
13. FATHER'S NAME <u>ROBERT COPPINGER</u>		14. MOTHER'S MAIDEN NAME <u>CAROLYN LEA SHIPP</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>	
18. <u>77550 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ANEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Rh INCOMPATIBILITY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4.40</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/2/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/2</u> 19 <u>69</u> to <u>7/2</u> 19 <u>69</u> and that (I) (we) last saw the deceased alive on <u>7/2</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>7/2/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>VANIDA VONGVATUNYU</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL BALTIMORE, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Calverton Cem</u>	
24D. LOCATION <u>BALTIMORE</u>		24E. FUNERAL DIRECTOR <u>[Signature]</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1969</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. ADDRESS <u>[Signature]</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6909	
1. NAME OF DECEASED (Type or Print) MARGARET E. POLK				2. DATE AND HOUR OF DEATH July 6, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3587 Benzinger Road Baltimore, Maryland 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2551 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3587 Benzinger Road	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1908	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Emory McCullough			14. MOTHER'S MAIDEN NAME Ada Jones		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Ernest L. Polk, 3587 Benzinger Rd. 21229 ADDRESS		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary thrombosis</i> (B) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive Sclerotic C.V. Disease</i> (C) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Obesity</i> </div> <div style="width: 10%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>8-10 years</i> </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June</i> 19 <i>66</i> to <i>July 6</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>June</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John F. Coolahan</i> M.D.				23B. DATE SIGNED <i>7/8/69</i>	
23C. PHYSICIAN'S NAME (Type) Dr. John F. Coolahan				23D. ADDRESS 4201 Wilkens Avenue, Balto., Md. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-1969		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1969</i>		25B. NAME OF REGISTRAR <i>Howard H. Hubbard, M.D.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6910

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Marshall, James M</i>		2. DATE AND HOUR OF DEATH <i>7/6/69 10:20 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Good Samaritan Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2435 Pickwick Rd. 2833</i>		
5. SEX <i>Male</i>	6. RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 2, 1895</i>	9. AGE (In years lost birthday) <i>74</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Better Business Bur.</i>		11. BIRTHPLACE (State or foreign country) <i>N. J.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			13. FATHER'S NAME <i>James M. Marshall</i>		
14. MOTHER'S MAIDEN NAME <i>Wilhelmina Sturges</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO. <i>216-09-5043A</i>			17. INFORMANT ADDRESS <i>Mrs. Edith C. Marshall 2434 Pickwick Rd.</i>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Branchogenic Carcinoma</i>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>8 months</i>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Arteriosclerotic cardiovascular disease</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>X</i> (this hospital) attended the deceased from <i>4/1/69</i> 19 to <i>7/6/69</i> 19, that <i>X</i> (we) last saw the deceased alive on <i>7/6/69</i> 19 and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>Paul J. Edgar, M.D.</i>				23B. DATE SIGNED <i>7/6/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Paul J. Edgar, M.D.</i>				23D. ADDRESS <i>Good Samaritan Hospital, Balto, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-8-1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lakewood</i>	
24D. LOCATION <i>Bowling Green, Va.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JULY 1969</i>			
25B. NAME OF REGISTRAR <i>E. J. Edgar, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>G. Howard Strong 3207 W. North Ave.</i>			

Bracebridge, Ontario 8-10-1912

Dear Mr. [illegible]

Yours very truly

[illegible signature]

Enclosed find [illegible]

Yours very truly

[illegible signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 6911		CERTIFICATE OF DEATH		REG. NO. 69 6911	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				GEORGE A. HULL		JULY 6, 1969 3:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		MARYLAND - BALTIMORE 2745			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
UNION MEMORIAL HOSPITAL 4389 & CALVERT ST. BALTIMORE MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER		6217 HARFORD ROAD			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
M	W		10-7-1897	71					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Draftsman			Retired			MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
GEORGE A. HULL				CHARLOTTE HENNEKEN					
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			217-03-8618		Myrtle A. Hull - 6217 Harford Rd.				
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest Chronic obstructive lung disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (this hospital) attended the deceased from JULY 5 1969 to JULY 6 1969 that (we) lost saw the deceased alive on JULY 6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Evelyn P. Navarro M.D.				JULY 6, 1969					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
EVELYN P. NAVARRO		THE UNION MEMORIAL HOSPITAL 4389 & CALVERT ST. BALTIMORE, MARYLAND							
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)			
Burial	7/9/69	Gardens of Faith Cem.		Baltimore		Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 9 1969		Robert E. Taylor, M.D.		Robert C. Altenburg Funeral Home, Inc.		6809 Harford Rd. - Balto., Md. 21214			

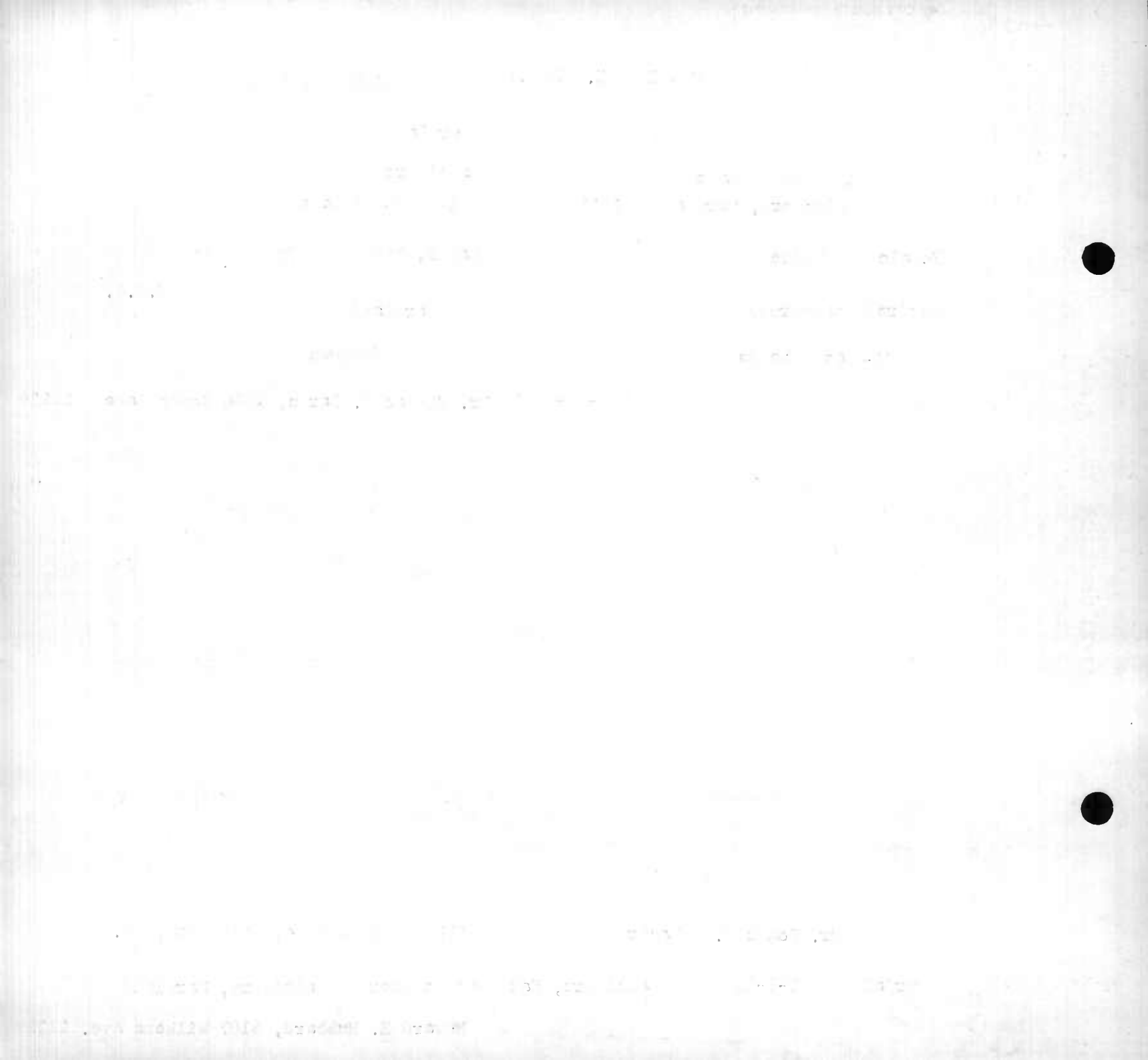
THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		GOLDIE I. PARKS		2. DATE AND HOUR OF DEATH July 4, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		2834	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		C. CITY OR TOWN Baltimore	
1006 Cooks Lane Baltimore, Maryland 21229		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1006 Cooks Lane	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1896	9. AGE (In years lost birthday) 73	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Lewis		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-5982		17. INFORMANT Mr. Thomas D. Parks, 1006 Cooks Lane 21229	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Broncho pneumonia Arteriosclerotic C-V Dis. with left hemiplegia (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus (C) Osteoarthritis		Terminable years years years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1955 to July 4, 1969 19 that (I) (we) last saw the deceased alive on July 3rd 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis R. Maser M.D.		23B. DATE SIGNED 7/5/69			
23C. PHYSICIAN'S NAME (Type) Dr. Louis R. Maser		23D. ADDRESS 2724 Smith Avenue, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-7-1969	24C. NAME OF CEMETERY or CREMATORY Baltimore, National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave, 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 6913

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bernardine M. Schultcheis

2. DATE AND HOUR OF DEATH

7-7-69

8:12 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

26024 Patasco Ave. Apt 2-C

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

21 4/35

9. AGE (in years last birthday)

34

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Gas & Elec. Co.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John J. Bayliss

14. MOTHER'S MAIDEN NAME

Julia T. Coneavage (Bayliss)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-32-0609

17. INFORMANT

John J. Bayliss 2904 Hollins Ferry Rd. 21230

ADDRESS

18.

255.21

CAUSE OF DEATH

1) Pharyngeal carcinoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

2) Malignant Hypertension

3) C-VIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *7/1 4 1969* to *7/7 1969* that (I) (we) last saw the deceased alive on *7/7 1969* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Makipoul

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

7-7-69

23C. PHYSICIAN'S NAME (Type)

HOUSHANG - MAKIPOUL

23D. ADDRESS

Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-10-69

24C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Wash. Blvd. Howard Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 9 1969

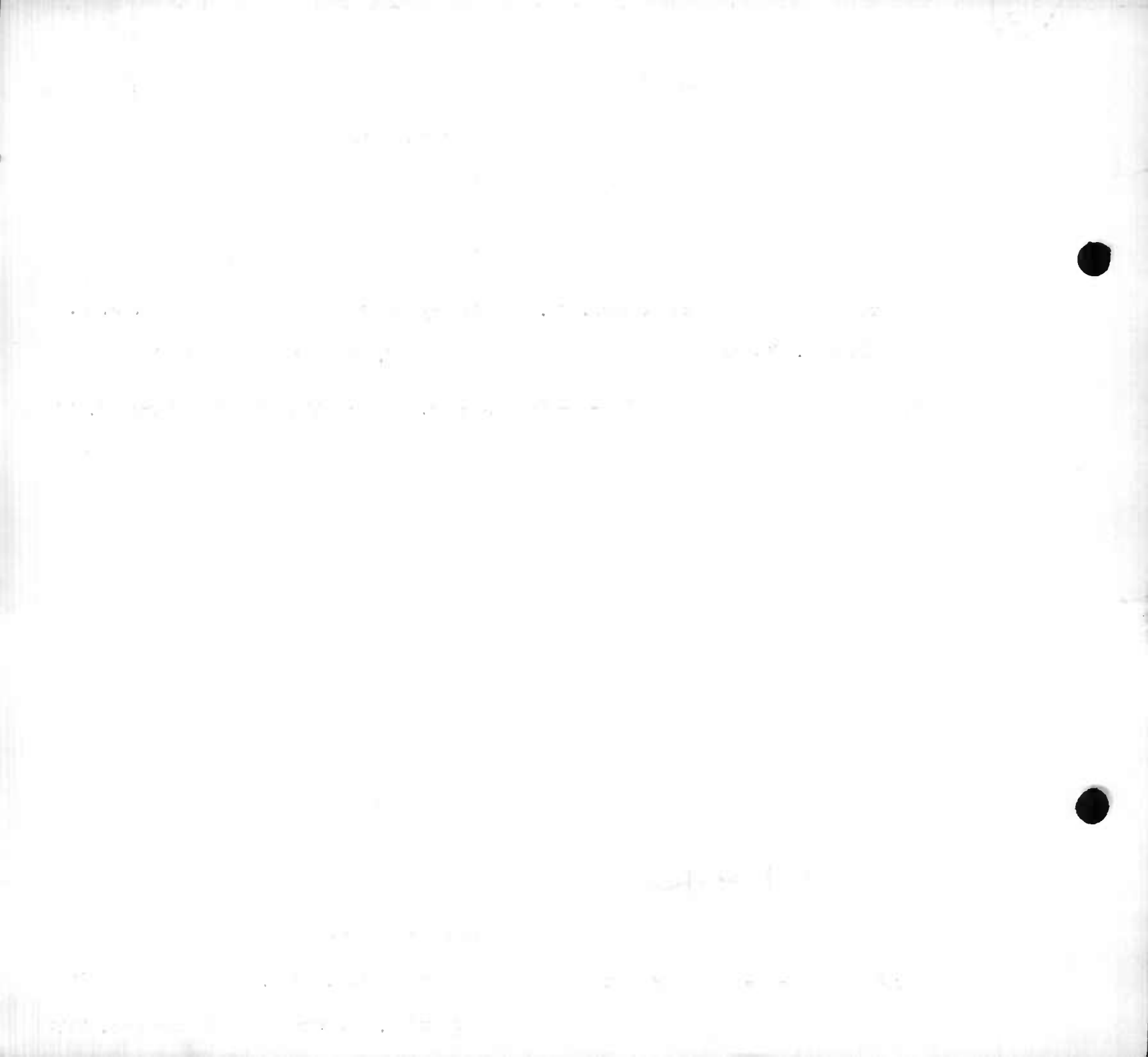
25B. NAME OF REGISTRAR

Robert E. Taber, M.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave. 21229

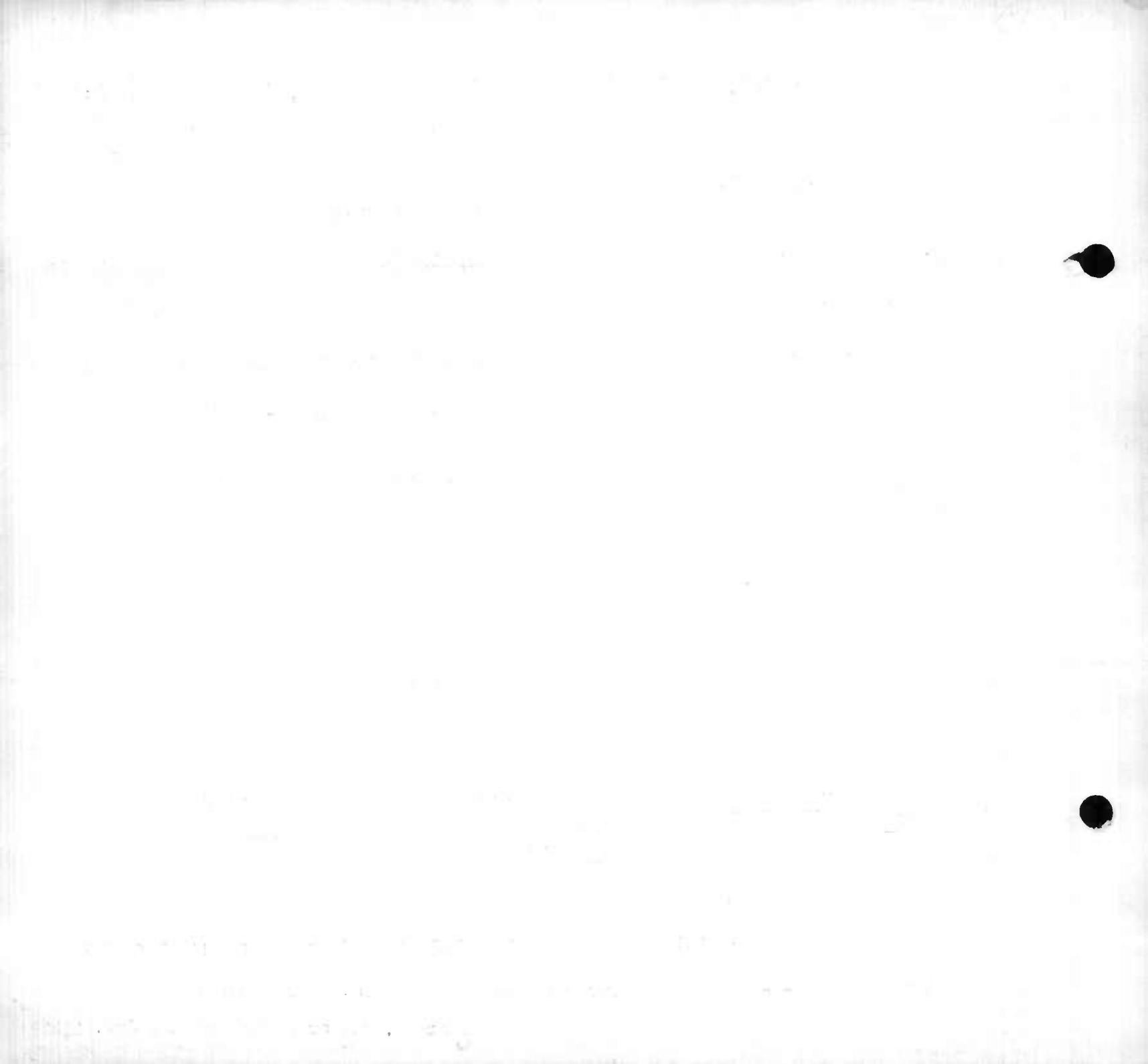
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

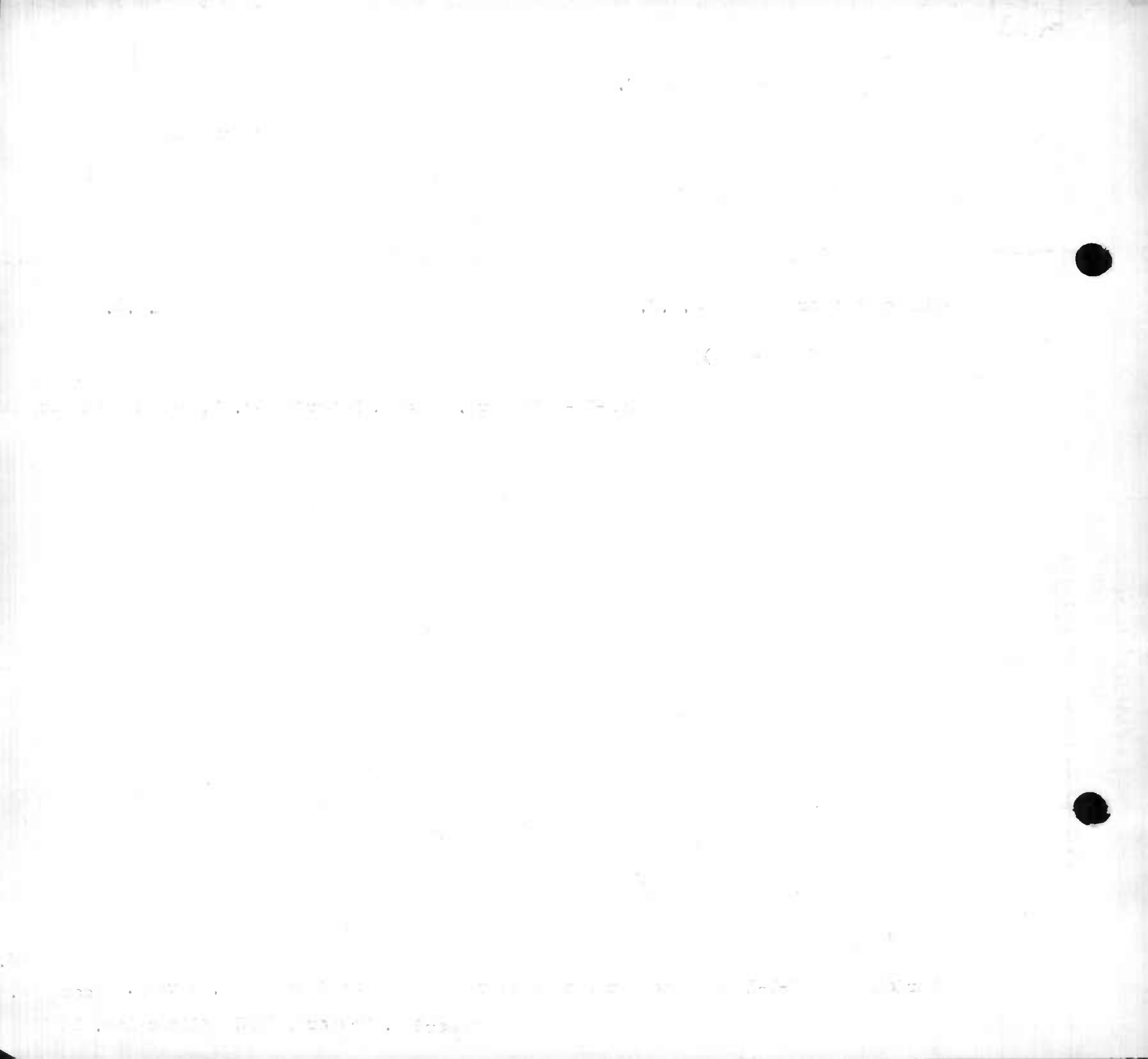
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6914 4	
BIRTH NO. 69-11979 69 6914		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BOYER, BABY BOY JEREMY CRAIG		JULY 2, 1969 9:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST AGNES HOSPITAL		MARYLAND		2551	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3725 WILKENS AVE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	07 02 69		3 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
INFANT				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
MELVIN C BOYER		XXXXXXXXXXXX Rockline Bodick			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				ST AGNES RECORDS-BALTO MD 21229	
18. 7569 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
[This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]		Multiple Congenital Anomalies 3hr 30min			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 2 1969 to JULY 2 1969					
that (X) (we) last saw the deceased alive on JULY 2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (He) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE/SIGNED			
MARSTON A YOUNG		3 July 69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MARSTON A YOUNG		ST AGNES HOSP/ CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-5-1969		Loudon Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 9 1969		Robert E. Taylor, M.D.		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6915		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6915	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>McCurdy, Wilbert G.</i>			2. DATE AND HOUR OF DEATH <i>7-4-69 12:40 a.m.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Howard Co.</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>			C. CITY OR TOWN <i>Hanover</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>Rd #2 Box 48</i>		
5. SEX <i>Male</i>	6. RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-18-1908</i>	9. AGE (In years last birthday) <i>61</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office Manager</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>A.D.T.</i>	11. BIRTHPLACE (State or foreign country) <i>OHio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>? (Unknown)</i>			14. MOTHER'S MAIDEN NAME <i>Minnie Knox</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>105-10-9623</i>	17. INFORMANT <i>Mrs. Anna M. McCurdy, Rt. 2, Box 48 Hanover, Md.</i>		
18. <i>410.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Postero septal myocardial infarction</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Pneumonia (early)</i>					
19A. DATE OF OPERATION <i>2 -</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-1-69</i> to <i>7-4-69</i> that (I) (we) last saw the deceased alive on <i>7-4-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Abdolhamid Ghiladi</i>			23B. DATE SIGNED <i>7-4-69</i>		
23C. PHYSICIAN'S NAME (Type) <i>Abdolhamid Ghiladi</i>			23D. ADDRESS <i>Mercy Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-7-1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Washington Blvd. Dorsey. Howard Co.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1969</i>		25B. NAME OF REGISTRAR <i>Howard H. Hubbard</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

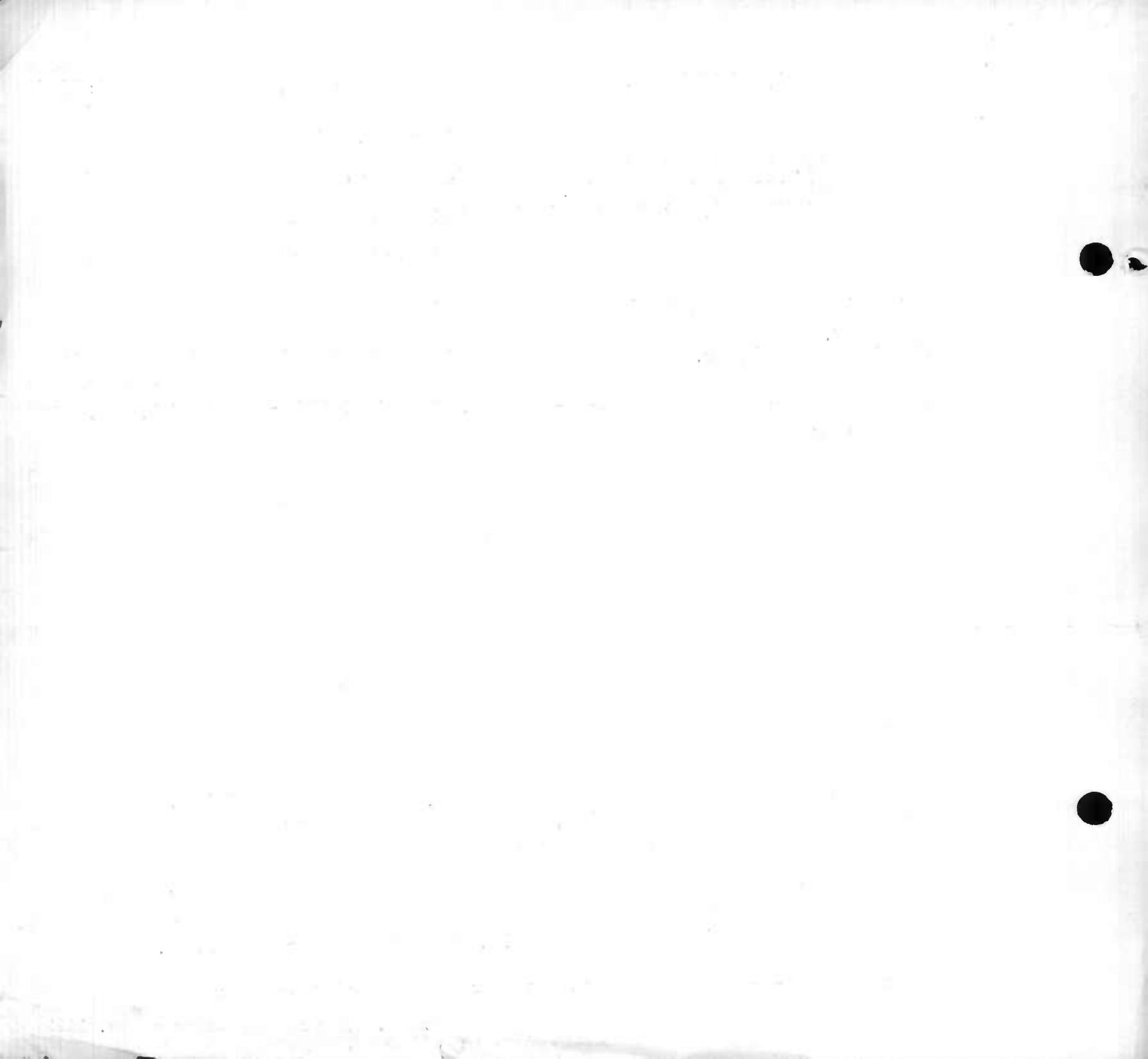
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				M.			
GLADYS J. LINZ				July 6, 1969							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland				B. COUNTY			
80 921 Rockhill Avenue Baltimore, Maryland 21229				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 921 Rockhill Avenue											
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1908		9. AGE (In years last birthday) 61		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hildebrand				14. MOTHER'S MAIDEN NAME Katherine Kreiner							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-18-3336		17. INFORMANT Mr. George J. Linz, 921 Rockhill Ave., 21229				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 RS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 3/9/67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal tumor				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/15/69 to 6/9/69 that (I) (we) last saw the deceased alive on 6/9/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE Earl Pass				23B. DATE SIGNED 7/7/69							
23C. PHYSICIAN'S NAME (Type) Dr. Earl I. Pass				23D. ADDRESS 4001 Wilkens Avenue, Balto., Md. 21229							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-9-69				24C. NAME OF CEMETERY or CREMATORY Ludon Park Cemetery			
24D. LOCATION Baltimore, Maryland											
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint lines and shapes are visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

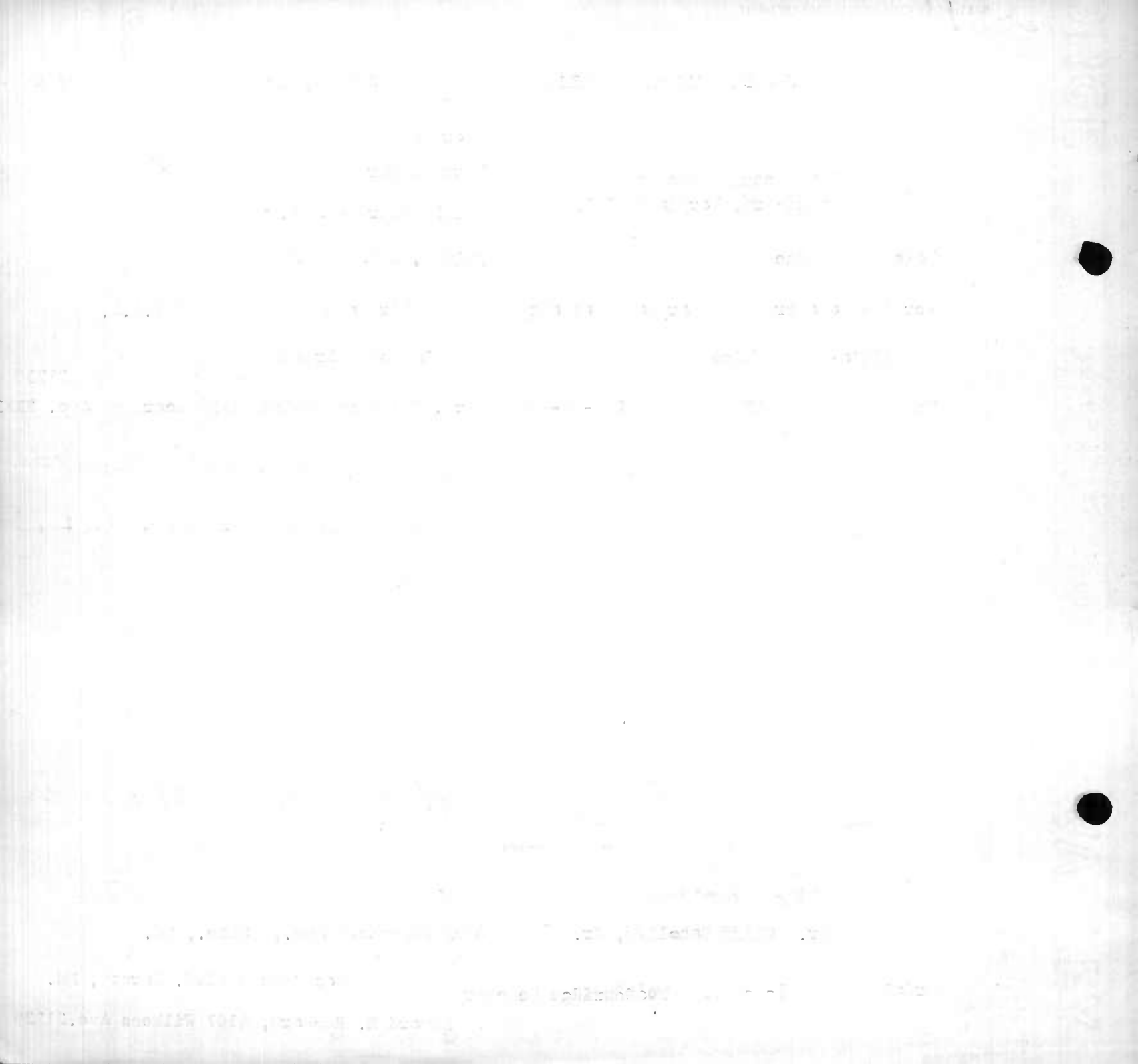
69 6917		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6917	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) DORSEY, RICHARD W.			2. DATE AND HOUR OF DEATH JULY 6, 1969 5:55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND, ANNE ARUNDEL 5200		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKESN & CATON AVES. BALTIMORE, MARYLAND 21229			C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE			6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/26/14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAINMAN			10B. KIND OF BUSINESS OR INDUSTRY RAILROAD B & O		9. AGE (In years last birthday) 55
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME F. WILLIAM DORSEY, Sr.			14. MOTHER'S MAIDEN NAME RUTH (NICODEMUS) DORSEY DEC'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES WW2			16. SOCIAL SECURITY NO. 214-01-8661		17. INFORMANT WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTIMORE, MD. 21229
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE GASTRO ENTERITIS + DEHYDRATION / 24 HOURS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYELOBLASTIC LEUKEMIA FIVE WEEKS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 22, 1969 to JULY 6, 1969 that (X) (we) last saw the deceased alive on JULY 6, 1969 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (M) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julio Freijanes, M.D.			23B. DATE SIGNED 7/6/69		23C. PHYSICIAN'S NAME (Type) JULIO FREIJANES
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7-9-69		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969			25B. NAME OF REGISTRAR Howard H. Hubbard, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229
24D. LOCATION Baltimore, Maryland			24E. LOCATION City, town, or county (State)		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6918
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH TYSON WHITE		2. DATE AND HOUR OF DEATH July 4, 1969 9 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1936 Deering Avenue Baltimore, Maryland 21230		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Morrell Park D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1936 Deering Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1915	9. AGE (In years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Manager		10B. KIND OF BUSINESS OR INDUSTRY Maryland Casualty		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William White		
14. MOTHER'S MAIDEN NAME Louise Arnold		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		
16. SOCIAL SECURITY NO. 214-01-9934		17. INFORMANT ADDRESS 21230 Mrs. Elizabeth White, 1936 Deering Ave. XXX		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Crown Thrombosis</i> B) DUE TO, OR AS A CONSEQUENCE OF: <i>Crown artery sclerosis</i> C) <i>age</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/28 1969 to 7/4 1969, that (I) last saw the deceased alive on 6/18 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Cliff Ratoliff, Jr.</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/7/69
23C. PHYSICIAN'S NAME (Type) Dr. Cliff Ratoliff, Jr.		23D. ADDRESS 4605 Edmondson Ave., Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-8-1969	24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd. Dorsey, Md.
25A. DATE REC'D BY HEALTH DEPT. JULY 1969	25B. NAME OF REGISTRAR <i>James E. Taylor, M.D.</i>	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6919

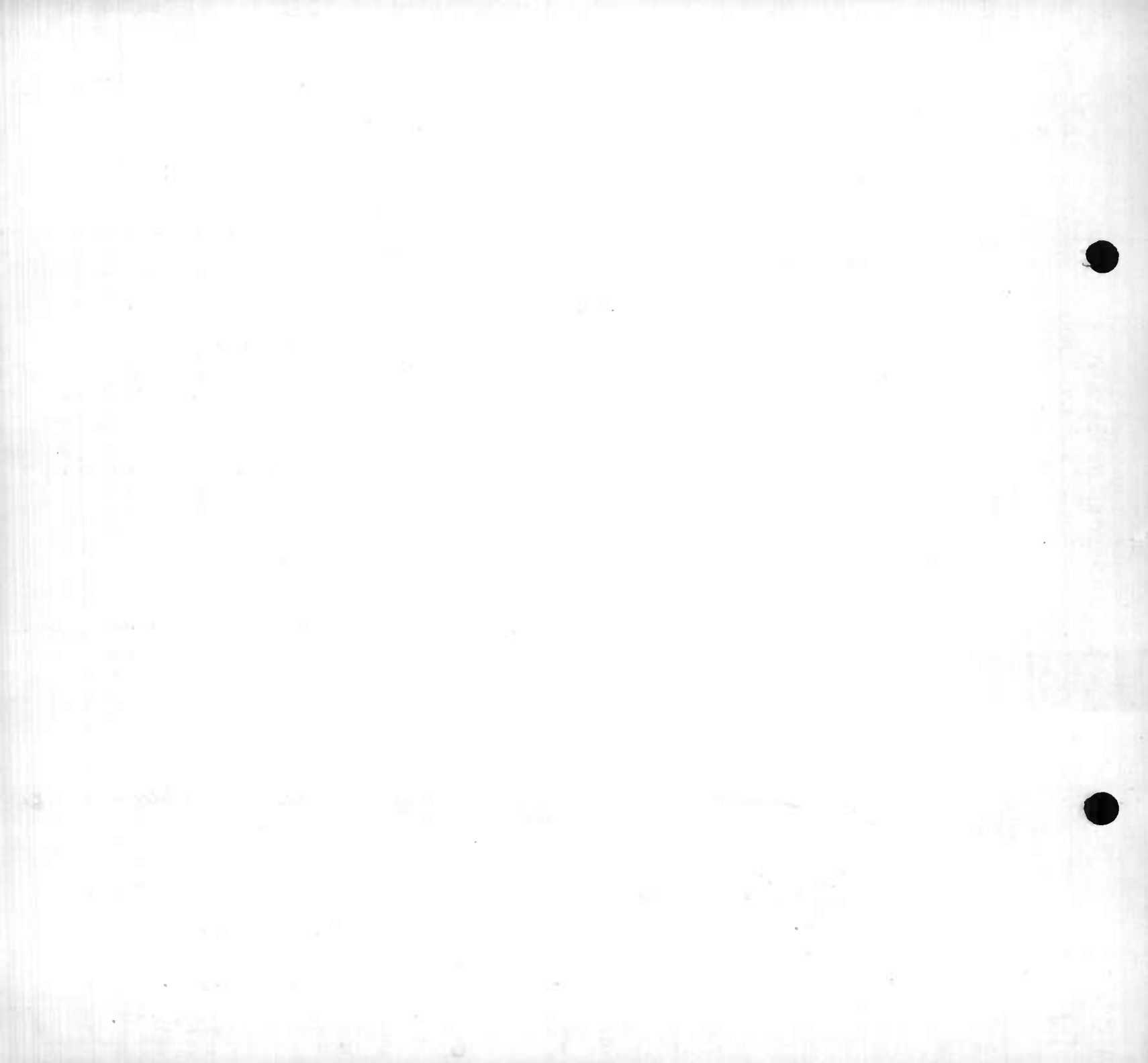
BIRTH NO.

1. NAME OF DECEASED Elizabeth (Type or Print) ANNIE E. HAYES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 820 N. Washington St.		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour	
				July	5	69	5:55p
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 704		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 820 N. Washington St.			
9. DATE OF BIRTH 7/29/1897		10. AGE (In years last birthday) 71		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Welby		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Julia Kinavy			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT Walter R. Hayes, son, 3938 Loundes Ave.		ADDRESS 21218	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
ACTUAL SIGNATURE Werner H. Spitz M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) Werner H. Spitz		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
		24D. LOCATION (City, town, or county) Baltimore, Md.		24E. NAME OF FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601 E. Madison St.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969		25B. NAME OF REGISTRAR Walter E. Faber, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601 E. Madison St.	

ACADEMY SECOND

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

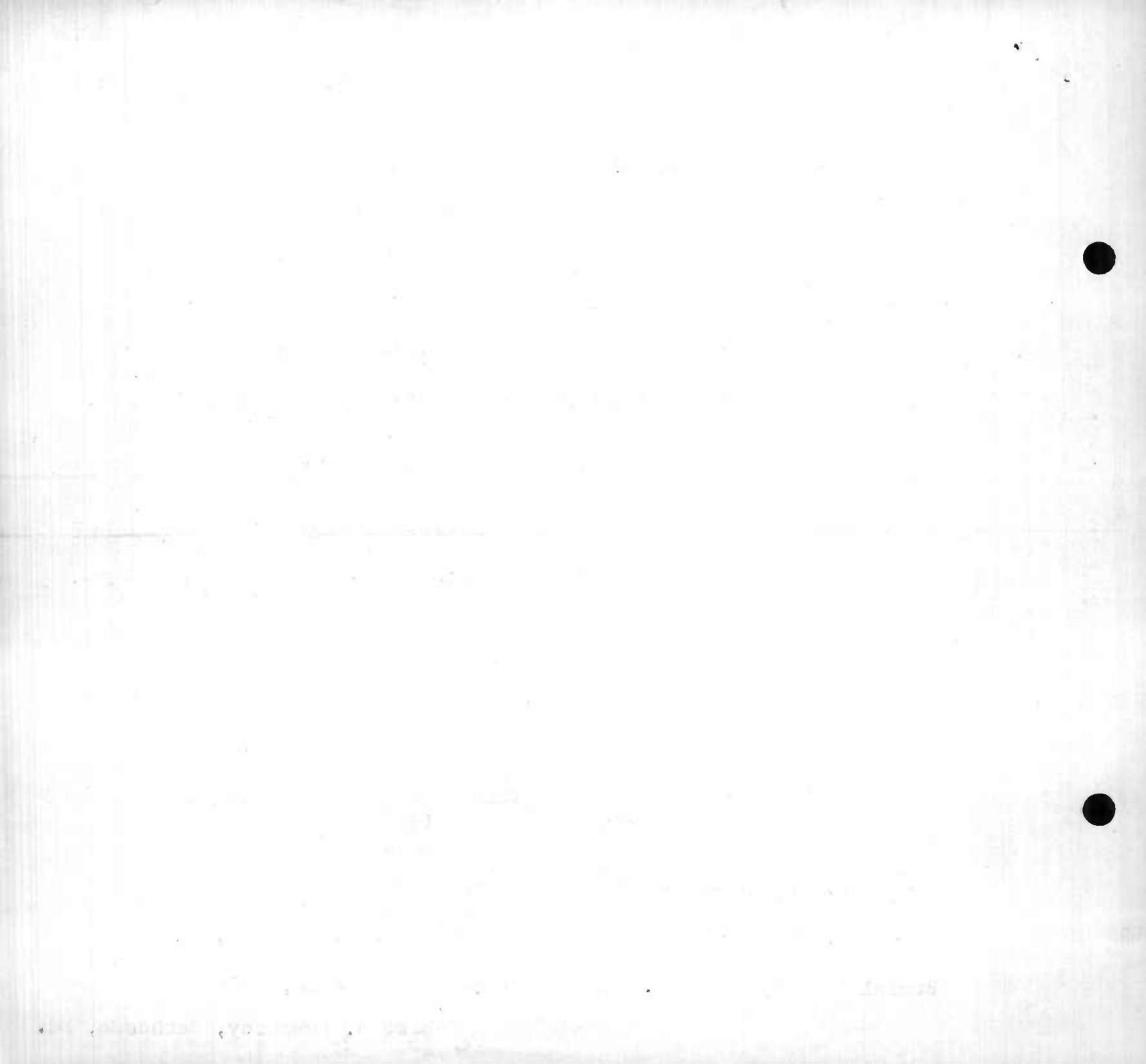
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
69 6920		CERTIFICATE OF DEATH		69 6920
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
ZOFIA UCZYNSKI		July 4, 1969 11:40 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY
		Md. 21213		
90 Bolton Hill Nursing Home		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		3513 Elmora Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5/6/1893	76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		at home		Poland
12. CITIZEN OF WHAT COUNTRY?		U.S.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Adam Turski		Emilia Milinsla		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
				Mildred Morgan, friend, 2802 Erdman Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 wks
		Bronchopneumonia		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Parkinson's Disease		many years
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 21 1969 to July 4 1969, that (I) (we) last saw the deceased alive on July 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE			23B. DATE SIGNED	
Stephen Toms, MD			7/7/69	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS	
Dr. Stephen Toms			1712 Winford Road	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	7/8/69	Holy Rosary Cemetery	Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		
JUL 9 1969	Robert E. Tabor, M.D.	Schimunek Funeral Home, Inc. 3331 Brehms Lane		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6921
C-450		69 6921		CERTIFICATE OF DEATH	
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			Terrance Paul Callahan		
2. DATE AND HOUR OF DEATH			July 1, 1969 6:10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Parkway			A. STATE Ohio B. COUNTY Xenia		
5. SEX M			6. RACE W		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5/8/48		
9. AGE (In years lost birthday) 21			10. Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10B. KIND OF BUSINESS OR INDUSTRY College		
11. BIRTHPLACE (State or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Francis Callahan			14. MOTHER'S MAIDEN NAME Shirley Nelson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 282-44-5120		
17. INFORMANT Records- US PHS Hospital, Balto, Md.			ADDRESS		
18. 204.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral herniation Leukemia of brain Acute lymphatic leukemia (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal Months 2 yrs.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 25 19 69 to July 1 19 69, that (I) (we) last saw the deceased alive on July 1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Sutherland, M.D. DEGREE				23B. DATE SIGNED 7/2/69	
23C. PHYSICIAN'S NAME (Type) John C. Sutherland, MD DEGREE				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/69		24C. NAME OF CEMETERY or CREMATORY St. Brigid Cemetery	
24D. LOCATION Xenia, Ohio					
25A. DATE REC'D BY HEALTH DEPT JUL 9 1969		25B. NAME OF REGISTRAR Robert A. Pumphrey, M.D.		25C. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>D-260</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6922</u>			
1. NAME OF DECEASED (Type or Print) <u>CELIA DE AGRO</u>						2. DATE AND HOUR OF DEATH <u>7/1/69</u> <u>12:25 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>						C. CITY OR TOWN <u>ESSEX</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>9/12/93</u>			9. AGE (In years last birthday) <u>75 yrs.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>						10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		
13. FATHER'S NAME <u>ALFRED DEAGRO</u>						14. MOTHER'S MAIDEN NAME <u>?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>						16. SOCIAL SECURITY NO. <u>065-16-4743A</u>			17. INFORMANT <u>BCH RECORDS: 4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u>		
18. <u>412.317-250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>RESPIRATORY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PERFORATED DUODENAL ULCER</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>MULTIPLE MYOCARDIAL INFARCTIONS</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>1 WEEK</u> <u>1 YEAR</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DIABETES MELLITUS</u>											
19A. DATE OF OPERATION <u>3/6/24/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PERFORATE DUODENAL ULCER</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? <u>-</u>		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> <u>1969</u> to <u>7/1</u> <u>1969</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>[Signature]</u>						23B. DATE SIGNED <u>7/1/69</u>					
23C. PHYSICIAN'S NAME (Type) <u>ENRIQUE CASTRO MD</u>						23D. ADDRESS <u>4940 EASTERN AVENUE, BALTO., MD.</u> <u>BALTIMORE CITY HOSPITAL #21224</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/5/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JULY 1969</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>DE CONNELLY SONS</u>		ADDRESS <u>300 MACE</u>					

FUNERAL DIRECTOR: IMPORTANT

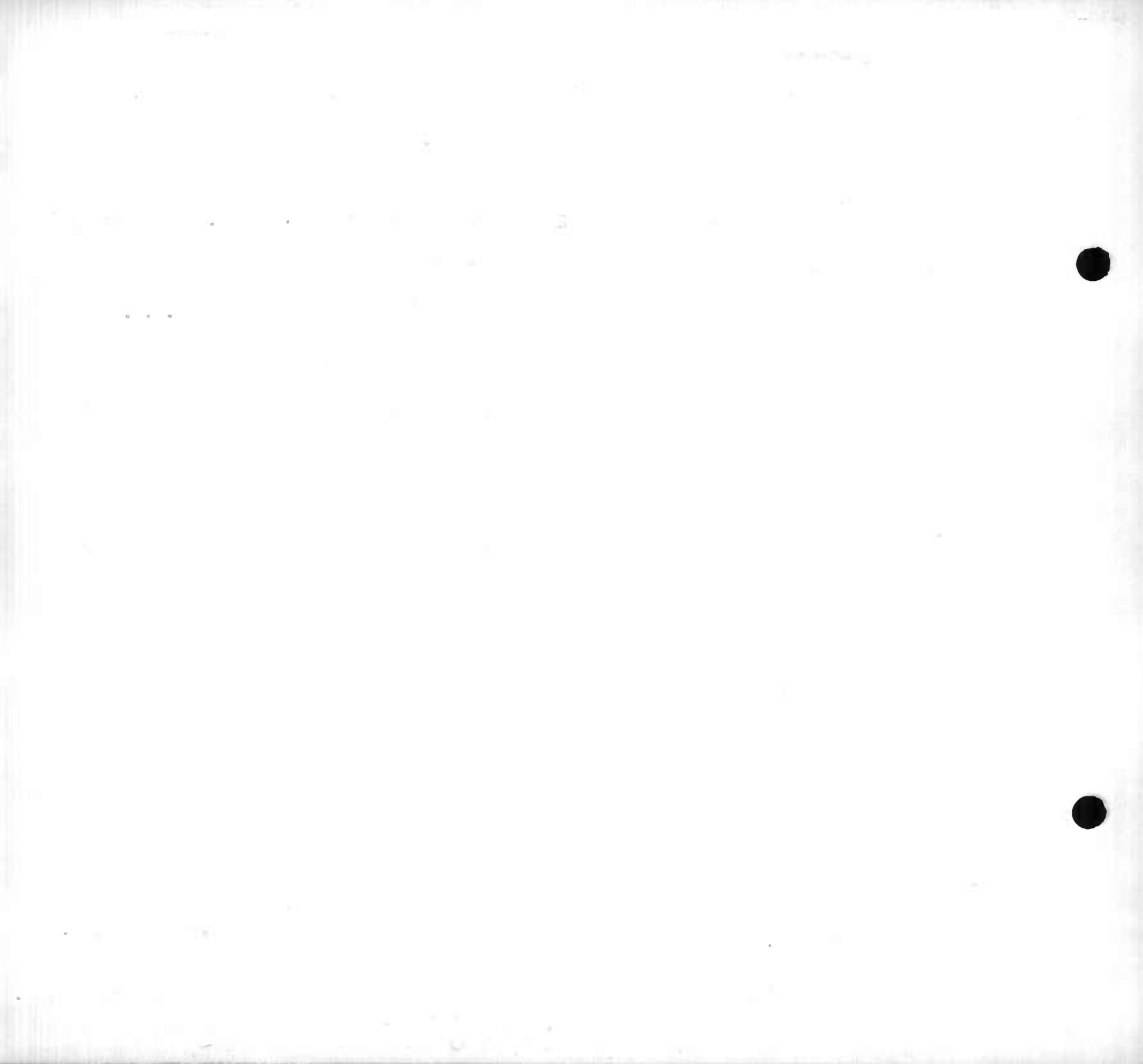
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) WILLIAM LINDEMAN					2. DATE AND HOUR OF DEATH 7-3-69 M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL					A. STATE MARYLAND B. COUNTY 5300				
					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 914 BARRON AVENUE				
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-13		9. AGE (In years last birthday) 56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOLD-MAKER		10B. KIND OF BUSINESS OR INDUSTRY BAUMGARTER CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME GEORGE LINDEMAN					14. MOTHER'S MAIDEN NAME UKN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216-09-0907		17. INFORMANT Edna L. Lindeman		
					ADDRESS same as above.				
18. 43391 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 1) C. V. A.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II					(A) IMMEDIATE CAUSE 1) cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF:				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6-30-1969 to 7-3-1969 that (I) (we) last saw the deceased alive on 7-3-1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE H. MAKIPOUR					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7/3/69	
23C. PHYSICIAN'S NAME (Type) HOUSHANG MAKIPOUR					23D. ADDRESS Mercy Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/69		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) Balto.		(State) md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969		25B. NAME OF REGISTRAR James E. Talbot, M.D.			25C. FUNERAL DIRECTOR John H. Connelly Sons			ADDRESS Essex, Md.	

$$\begin{array}{r}
 1969 \\
 31 \\
 \hline
 1938 \\
 1913 \\
 18 \\
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 31
 \end{array}$$

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>64-09694</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 6924</u>	
1. NAME OF DECEASED (Type or Print) <u>Harston, Baby Girl -Deborah Mae</u>				2. DATE AND HOUR OF DEATH <u>6-27-69</u> <u>15:06</u> a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>21224</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2004</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2402 Frederick Ave.</u> Apt. 3rd floor <u>21223</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-69</u>	9. AGE (In years last birthday) <u>1 month</u>	10. Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> <u>Baltimore City Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not Given</u>				14. MOTHER'S MAIDEN NAME <u>Harston, Deborah Mae</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue</u> <u>21223</u>			
18. <u>0359 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>SEPSIS, GRAM NEG</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>3.6 HR</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>26 MAY</u> 19 <u>69</u> to <u>27 JUNE</u> 19 <u>69</u> that (I) (we) lost saw the deceased alive on <u>27 JUNE</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lowell H. Kallen MD</u>				23B. DAYE SIGNED <u>27-JUN-69</u>		23C. PHYSICIAN'S NAME (Type) <u>Lowell H. Kallen</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Cremated</u>		<u>7/1/69</u>		<u>Baltimore City Hospitals</u>		<u>4940 Eastern Avenue, Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
<u>JULY 1969</u>		<u>James E. Ferguson, D.O.</u>		<u>69 HOSPITAL DISPOSAL</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-300 69 6925</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>54-57-78 69 6925</u>	
1. NAME OF DECEASED (Type or Print) <u>Baluy Boy Wood</u>			2. DATE AND HOUR OF DEATH <u>7-2-69</u> <u>11:05 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hops</u> <u>4940 Eastern Ave. 21224</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15/11</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3615 Wabash Ave. 21215</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-69</u>	9. AGE (In years last birthday) <u>N-Born</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>39</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Fitchenson</u>			14. MOTHER'S MAIDEN NAME <u>Sean Wood</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT ADDRESS <u>BCH Records: 4940 Eastern Ave. 21224</u>		
18. <u>720.94</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Primary apnea</u> (B) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Placental insufficiency</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-2-1969</u> to <u>7-2-69</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>7-2-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Teixera, M.D.</u>			23B. DATE SIGNED <u>7-2-69</u>		23C. PHYSICIAN'S NAME (Type) <u>OTTO TEIXEIRA</u> <u>Otto Teixeira</u>
23D. ADDRESS <u>4940 Eastern Ave. 21224</u> <u>Baltimore City Hops</u>			24. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u>		
24A. DATE <u>7/3/69</u>		24B. NAME OF CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>		24C. LOCATION (City, town, or county) (State) <u>4940 Eastern Avenue, Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>62 HOSPITAL DISPOSAL</u>	

Letter from B.C.H.
7-24-69 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6926

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bryan, Mary

2. DATE AND HOUR OF DEATH

7-7-69

2:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital
1514 Division Street
Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

13 N. Vincent Street

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

12-27-42

9. AGE (in years last birthday)

26

10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph A. Bryan

14. MOTHER'S MAIDEN NAME

Mary M. Bryan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

214-40-4884

17. INFORMANT

ADDRESS

Mrs. Shirley Brown Sis. 16 N. Vincent St

18. 250.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

DIABETIC ACIDOSIS + COMA 6/26/69

(B) DUE TO, OR AS A CONSEQUENCE OF:

DIABETES MELLITUS

(C) DUE TO, OR AS A CONSEQUENCE OF:

HEPATIC INSUFFICIENCY

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-26-69 19 to 7-7-69 19 that (I) (we) last saw the deceased alive on 7-7-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Gilbert L. Banfield

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

7-7-69

23C. PHYSICIAN'S NAME (Type)

GILBERT L. BANFIELD, M.D.

23D. ADDRESS

Provident Hospital
1514 Division Street - Balti. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-10-69

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county) (State)

Brooklyn, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 9 1969

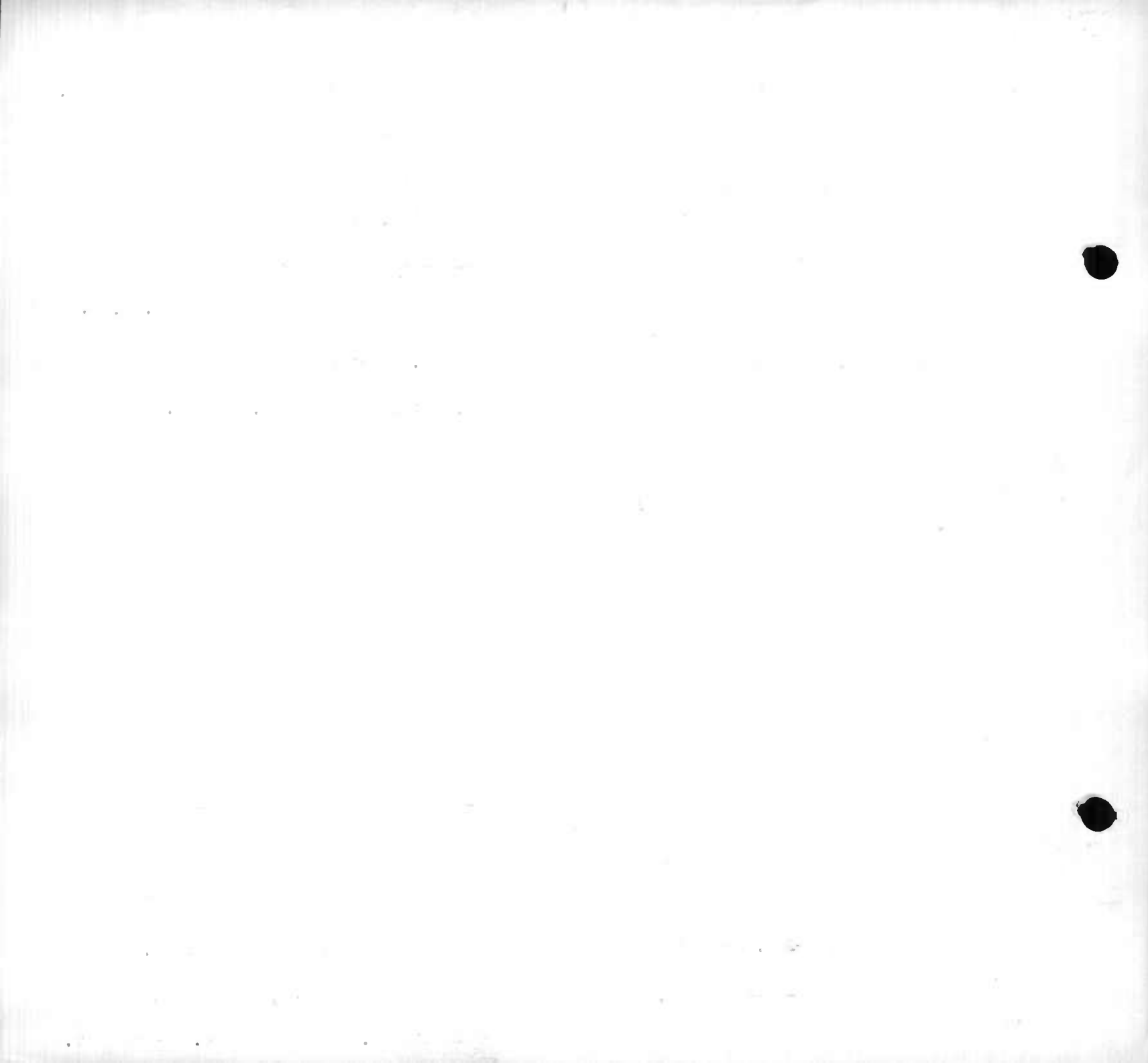
25B. NAME OF REGISTRAR

Charles E. J. J. J.

25C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St.

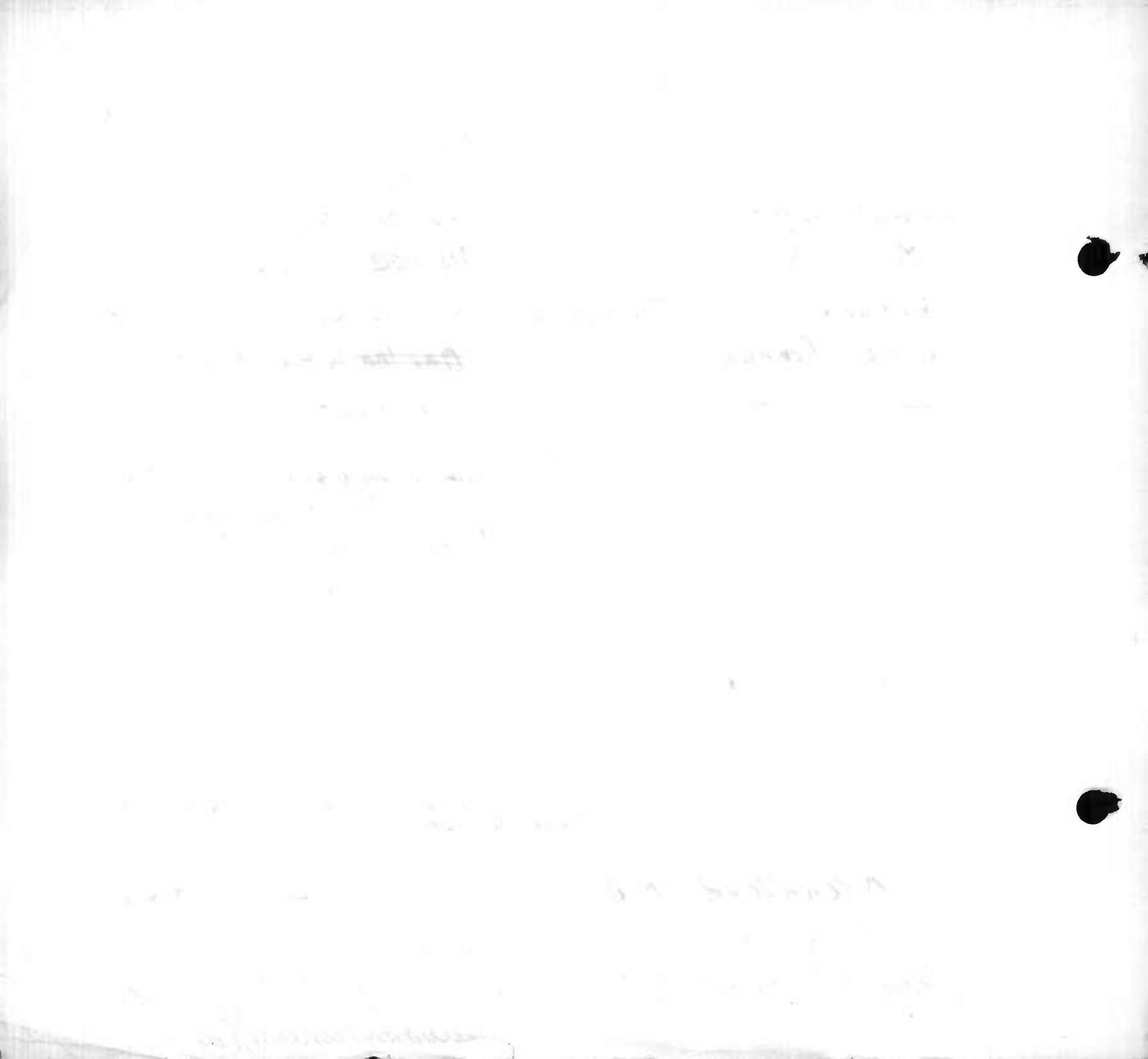
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6927</u>
BIRTH NO. <u>69 6927</u>		1. NAME OF DECEASED (Type or Print) <u>Willie Robinson</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>7/5/69</u> <u>8 P</u> M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>946 Saratoga St.</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/5/03</u>	9. AGE (in years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Longsterman</u>		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>
13. FATHER'S NAME <u>Willie Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Artha Hattie Flint</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Patrent</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinomatosis</u> <u>Ca of esophagus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>		(B) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>6/20/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pain</u>		20A. AUTOPSY? (Yes or No) <u>?</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>69</u> to <u>July 5</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>July 5</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>B. Ann Ward, M.D.</u>		23B. DATE SIGNED <u>7/5/69</u>		23C. PHYSICIAN'S NAME (Type) <u>B. Ann Ward</u>
23D. ADDRESS <u>University Hospital</u>		23E. DEGREE <u>—</u>		
24A. BURIAL CREMATION (Specify) <u>Burial</u>	24B. DATE <u>7/10/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Arboretum Memorial</u>		24D. LOCATION <u>9th</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1969</u>		25B. NAME OF REGISTRAR <u>James E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>
25D. ADDRESS <u>319 H. St.</u>		25E. CITY, TOWN, OR COUNTY <u>Baltimore</u>		



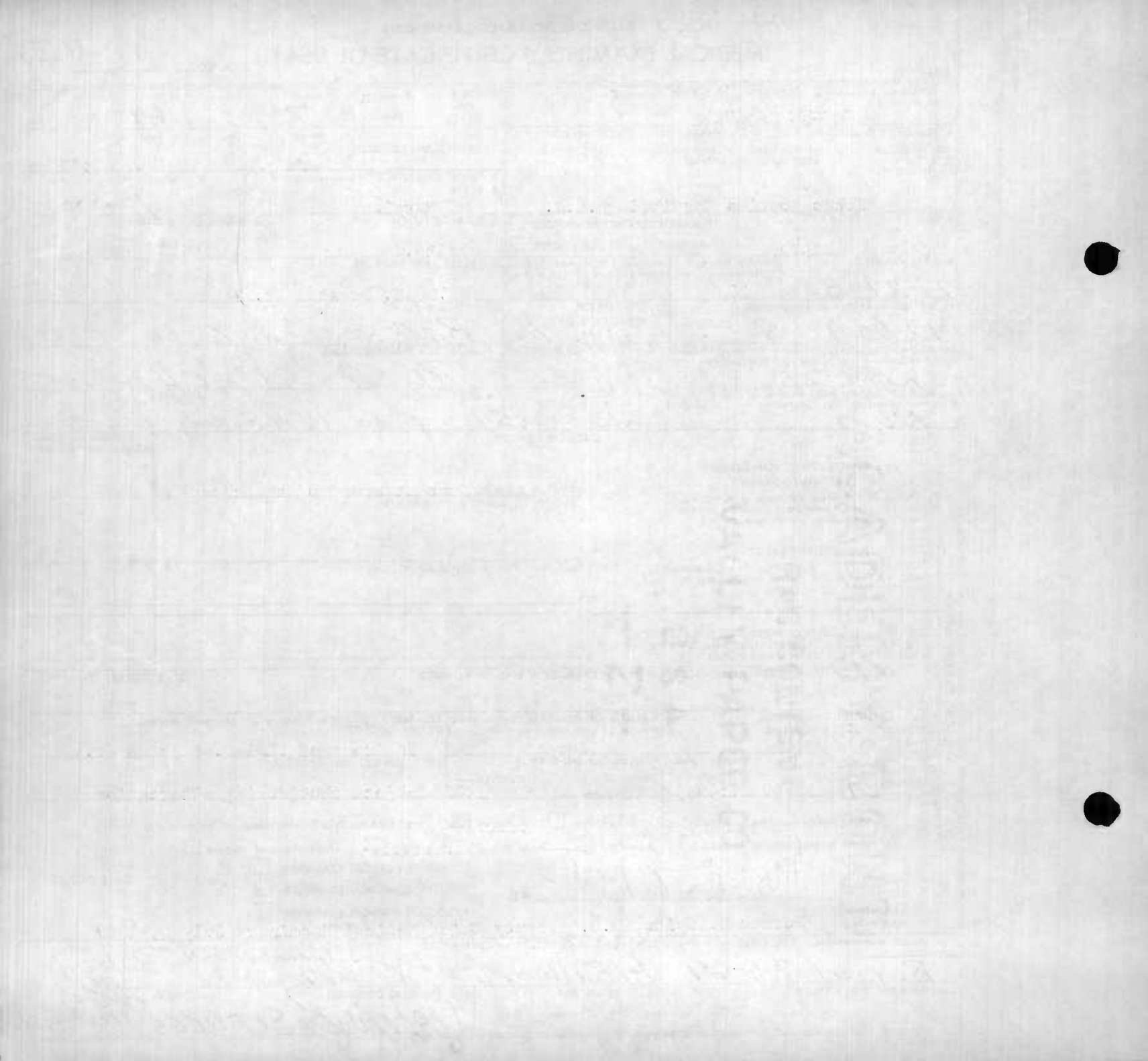
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 6928

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BAKER GASQUE or GASQUE, BAKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 5 Year 69 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) Johns Hopkins Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month July Day 5 Year 1969 Hour 8:03 p.m.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 9-09	
9. DATE OF BIRTH 12-24-35		10. AGE (In years lost birthday) 33	
11. BIRTHPLACE (State or foreign country) D. Md. S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BAKER GASQUE		14. MOTHER'S MAIDEN NAME ROSA W. WILLIAMS	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY FENCE CO.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO.		17. SOCIAL SECURITY NO. 213-32-5221	
18. INFORMANT Mrs. Rosa Williams		ADDRESS 4741	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Gunshot wound of the chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 7-5-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES		22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1001	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7 5 69 7:45 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject shot during altercation		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL-CREMATATION, REMOVAL (Specify) Burial		24B. DATE 7-9-69	
24C. NAME OF CEMETERY or CREMATORY Harburtown M.E.M.P.A.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969		25B. NAME OF REGISTRAR Werner U. Spitz, M.D.	
25C. FUNERAL DIRECTOR Calvin B. Scruggs		ADDRESS 1422 E. Preston St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 6929

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALBERT BELL		2. DATE AND HOUR OF DEATH JULY 7 1969 12 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 3 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 806	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 The Johns Hopkins Hospital				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 7/3/27 9. AGE (in years lost birthday) 42	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY Chevrolet Plant		11. BIRTHPLACE (State or foreign country) BALTO. Md.	
13. FATHER'S NAME John Bell				14. MOTHER'S MAIDEN NAME Marian Myers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 11-1-45 to 10-18-48		16. SOCIAL SECURITY NO. UNKNOW		17. INFORMANT Mrs. Marian Baker	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE GI BLEED ESOPHAGEAL VARICES CIRRHOISIS - PORTAL HYPERTENSION				ADDRESS 1706 W Durham St APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ALCOHOLISM					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (Myself) attended the deceased from JULY 6 19 69 to JULY 7 19 69 that (I) (we) last saw the deceased alive on JULY 7 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Seymour Levine, MD				23B. DATE SIGNED July 7, 1969	
23C. PHYSICIAN'S NAME (Type) SEYMOUR LEVINE MD				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-69		24C. NAME OF CEMETERY OR CREMATORY Balto. National	
24D. LOCATION (City, town, or county) (State) Frederick, Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969			
25B. NAME OF REGISTRAR Robert E. Jackson, M.D.		25C. FUNERAL DIRECTOR Robert B. Sengco		ADDRESS 1415 E. Preston	



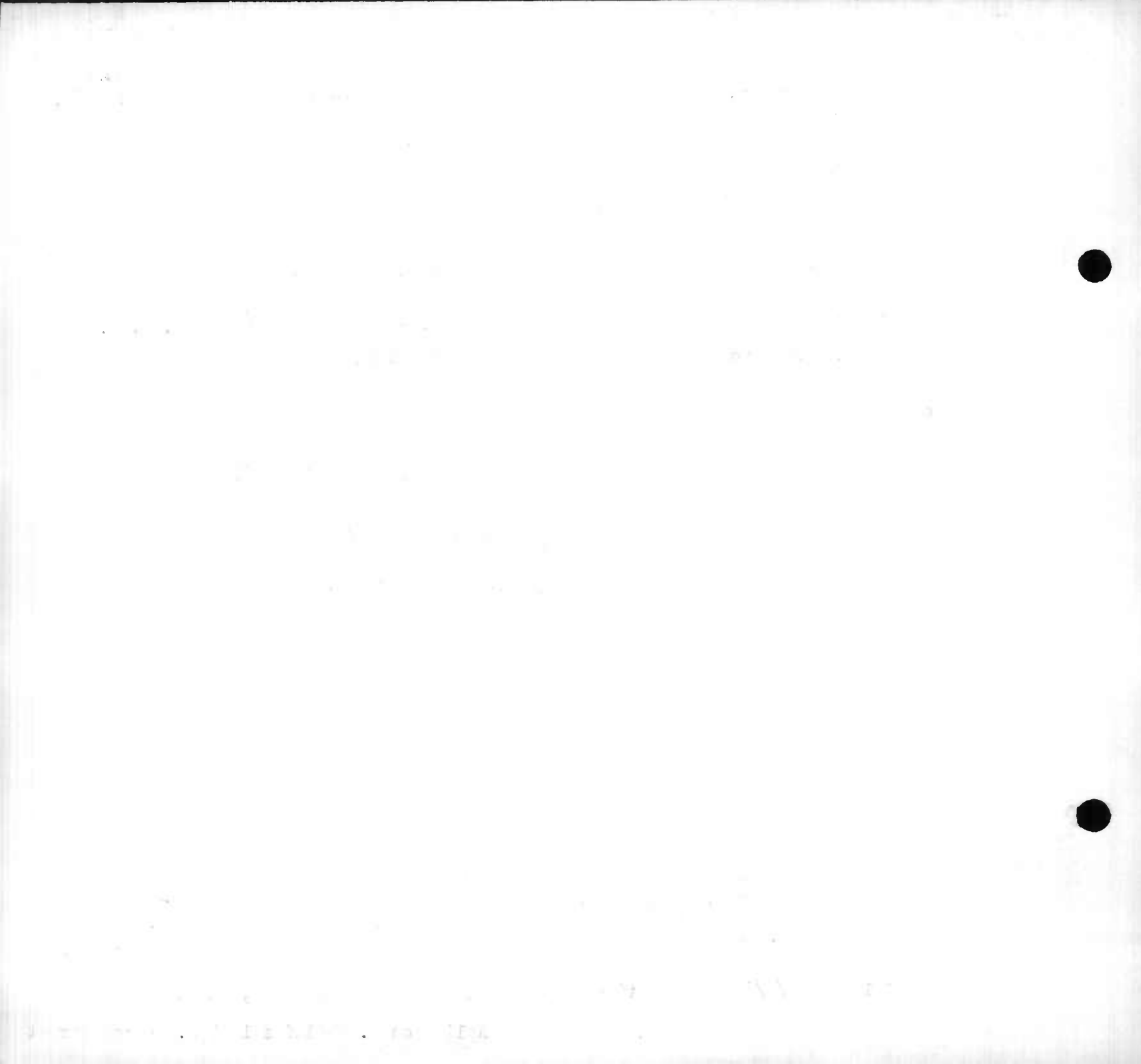
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 6930

BIRTH NO. 69 6930		2. DATE AND HOUR OF DEATH 7-4-69 6:45 p. M.	
1. NAME OF DECEASED (Type or Print) Hudson, Eunice		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1701 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 573 Moore Street	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11- - 31
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE in years (last birthday) 37
13. FATHER'S NAME Henry Lawrence		11. BIRTHPLACE (State or foreign country) Pennsylvania	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Mary Childs	
17. INFORMANT John Hudson		ADDRESS Same	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE diabetic Mellitus DUE TO, OR AS A CONSEQUENCE OF: (B) Metabolic Acidosis DUE TO, OR AS A CONSEQUENCE OF: (C) Renal Failure	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-30-69 to 7-4-69 and that (I) (we) lost saw the deceased alive on 7-4-69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. G. Tengeo		23B. DATE SIGNED 7-4-69	
23C. PHYSICIAN'S NAME (Type) Dr. G. Tengeo		23D. ADDRESS Provident Hospital, Inc. 1514 Division Street - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/9/69	24C. NAME OF CEMETERY OR CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
69 6931				69 6931	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Frank H. McDermott			2. DATE AND HOUR OF DEATH July 5, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3528 Ellerslie Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 903 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3528 Ellerslie Avenue		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1885	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10B. KIND OF BUSINESS OR INDUSTRY Dep't of Education	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James McDermott			14. MOTHER'S MAIDEN NAME ? Neville		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-0395	17. INFORMANT ADDRESS Mrs. M. Marie Bannan 3528 Ellerslie Avenue		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 1944 to present and that (I) (we) last saw the deceased alive on July 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 30 Vance Hooper DEGREE 23B. DATE SIGNED 7-5-69 23C. PHYSICIAN'S NAME (Type) 30 Vance Hooper DEGREE 23D. ADDRESS 3534 Ellerslie 21248 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7-8-1969 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969 25B. NAME OF REGISTRAR Robert E. Taylor M.D. 25C. FUNERAL DIRECTOR Wm. Cook Brooks 25D. ADDRESS Towson 1050 York Road 21204					

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THE BODY OF JOSEPH M. GILBERT HAS BEEN RELEASED AS NON-MEDICAL BY DR SPITZ
G 416 1
OF THE HEAD OF THE
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 6932		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 6932	
M.E. CASE NO. Anne Arundel Co. Md.					
1. NAME OF DECEASED (Type or Print) Gilbert, Joseph M.			2. DATE AND HOUR OF DEATH July 5, 1969 10:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS 5200		
			D. STREET ADDRESS (If rural, give location) 1794 B BELLE DRIVE		
5. SEX m	6. RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH June 3, 1969	9. AGE (In years last birthday) 32 days	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DANIEL E. GILBERT			14. MOTHER'S MAIDEN NAME SUSAN JURMANUBISH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT DANIEL E. GILBERT # 4		ADDRESS
18. I 746111 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO CONGENITAL HEART DISEASE (TRANSPOSITION GREAT VESSELS) (PDA) (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 30 days
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 8-7-5-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ligation of Patent Ductus		20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 5 19 69 to JULY 5 19 69, that (I) (we) last saw the deceased alive on JULY 5 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd A. Jacobs				23B. DATE SIGNED 5 July 69	
23C. PHYSICIAN'S NAME (Type) LLOYD A. JACOBS				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-8-69		24C. NAME of CEMETERY or CREMATORY HILLCREST	
24D. LOCATION (City, town, or county) ANNAPOLIS		24E. (State) A.A. MD.			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR John M. Taylor M.D.	
				ADDRESS ANNAPOLIS, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

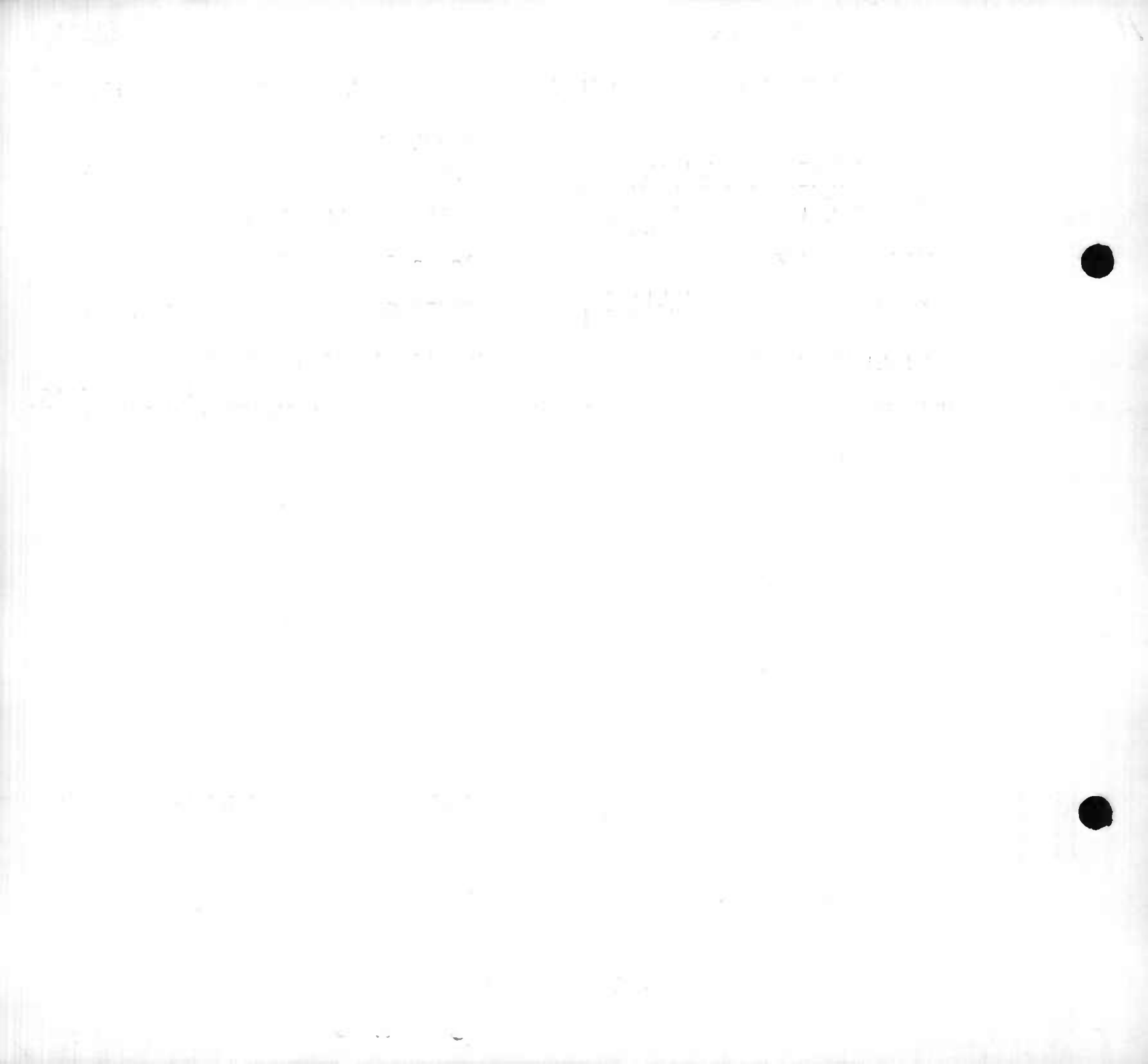
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BALTIMORE CITY HEALTH DEPARTMENT				69 6933	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <i>Montgomery Co. ind.</i>		69 6933		DATE AND HOUR OF DEATH 4 July 1969 4 20 P.M.	
1. NAME OF DECEASED (Type or Print) Donald E Furr		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY <i>Montgomery Co. 6500</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN GERMANTOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-23-66	
13. FATHER'S NAME TURNER FURR		14. MOTHER'S MAIDEN NAME MARY JENKINS		9. AGE (In years last birthday) 3	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. none		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT Mary A. Furr, mother same item # 4		ADDRESS Mary A. Furr, mother same item # 4		12. CITIZEN OF WHAT COUNTRY? USA	
18. 273.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF: (B) Cystic Fibrosis DUE TO, OR AS A CONSEQUENCE OF: (C) Pseudomonas Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Days Lifelong 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Electrolyte imbalance		10 days	
19A. DATE OF OPERATION 3 3 July 69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED increased Bronchial Secretions		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 7 19 69 to 4 July 19 69 that (I) (we) last saw the deceased alive on 4 July 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Russell W. Chesney M.P.		23B. DATE SIGNED 4 July 69		23C. PHYSICIAN'S NAME (Type) RUSSELL W. CHESNEY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/69		24C. NAME of CEMETERY or CREMATORY Forest Oak Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Galt, M.D.		25C. FUNERAL DIRECTOR Tyson Wheeler-1331 Rock. Pike, Rock. Md.	
24D. LOCATION Gaithersburg, Maryland		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 6934	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HUMPSTON, HOWARD KEITH				JULY 06, 1969 10:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL		WILKENS & CATON AVENUE		MARYLAND		BALTO. CO.	
BALTIMORE 21229, MD.				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				RELAY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER				1537 S. ROLLING ROAD			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. UNDER 24 Hrs. Hours
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	01-28-05	64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
FOREMAN				TENNESSEE		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM HUMPSTON				HARRIET (CARSON) HUMPSTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
UNKNOWN				414077467		ADDRESS BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				PULMONARY EDEMA AND ATELECTASIS			
ANTECEDENT CAUSES				(B) POST OPERATIVE Complication of DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				REMOVAL of CHEST WALL FIBROSARCOMA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				STERNAL & RT. RIBS RESECTION JULY 3, 1969			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
JULY 3 1969		FIBRO DERMITO SARCOMA PROLIFERATING		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from MAY 17 1969 to JULY 06 1969 that (I) (we) last saw the deceased alive on JULY 06 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
RALPH V. RAMIREZ, M.D.				7 July 1969			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Ralph V. Ramirez, M.D.				3350 WILKENS AVE BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/11/69		First Pres. Church Cemetery		White Pine, Tennessee	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 10 1969		Robert E. Gable, M.D.		Adrianse T. L.		1328 Sulphur Sp. Rd.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LAWRENCE McGRADY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1029 N. Stockton St.		3. DATE PRONOUNCED DEAD July 6, 1969		Month	Day	Year	Hour
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1601		
9. DATE OF BIRTH 00		10. AGE (In years last birthday) 22	11. BIRTHPLACE (State or foreign country) Latta, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Tom McGrady			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Madeline Sellers			
19. 5718 I		CAUSE OF DEATH		18. INFORMANT Mrs. Onnie Jentry			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty metamorphosis of the liver DUE TO, OR AS A CONSEQUENCE OF:		ADDRESS 3315 W. Garrison Ave.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/11/69		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. 7/10/1969		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR William J. Spicer		ADDRESS 916 E. North Ave.	

McADAM & CO.

19

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LELIA R. HOTT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 8, 1969		Hour 3:10 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year July 8, 1969		Hour 3:10 P.
6. SEX Female		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH July 13, 1917		10. AGE (In years last birthday) 51	11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Oliver Evans		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Unknown		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-24-7458		18. INFORMANT ADDRESS Mrs. Iona V. Wilhelm, 5303 Moravia Rd.
19. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7/11/69		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/9/69
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/69		24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN CEMETERY
24D. LOCATION (City, town, or county) (State) GLENBURNIE, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS LEONARD J. RUCK, INC. BALTO. MD.		

WILLIAM H. HARRIS

WILLIAM H. HARRIS

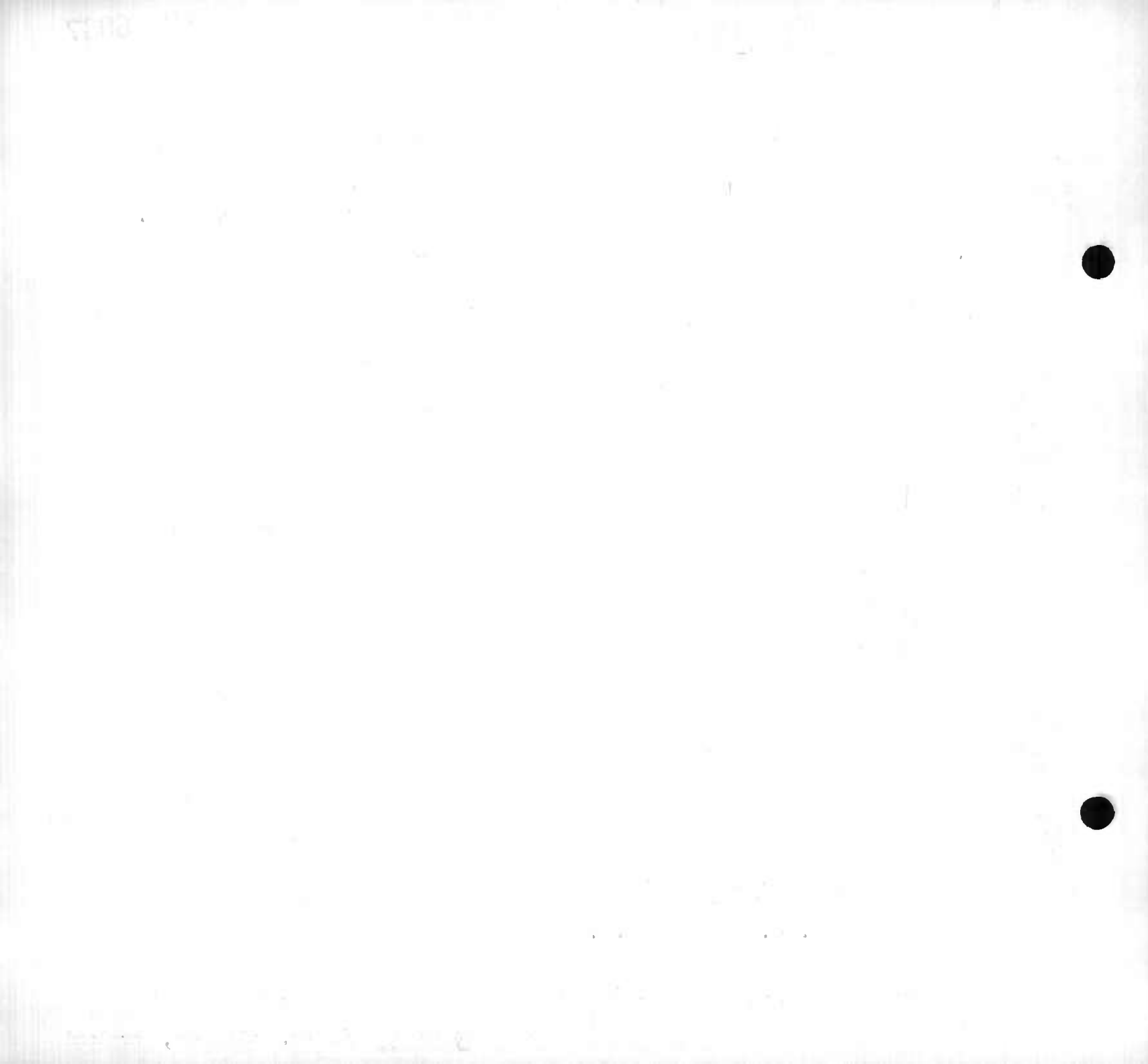
WILLIAM H. HARRIS

WILLIAM H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

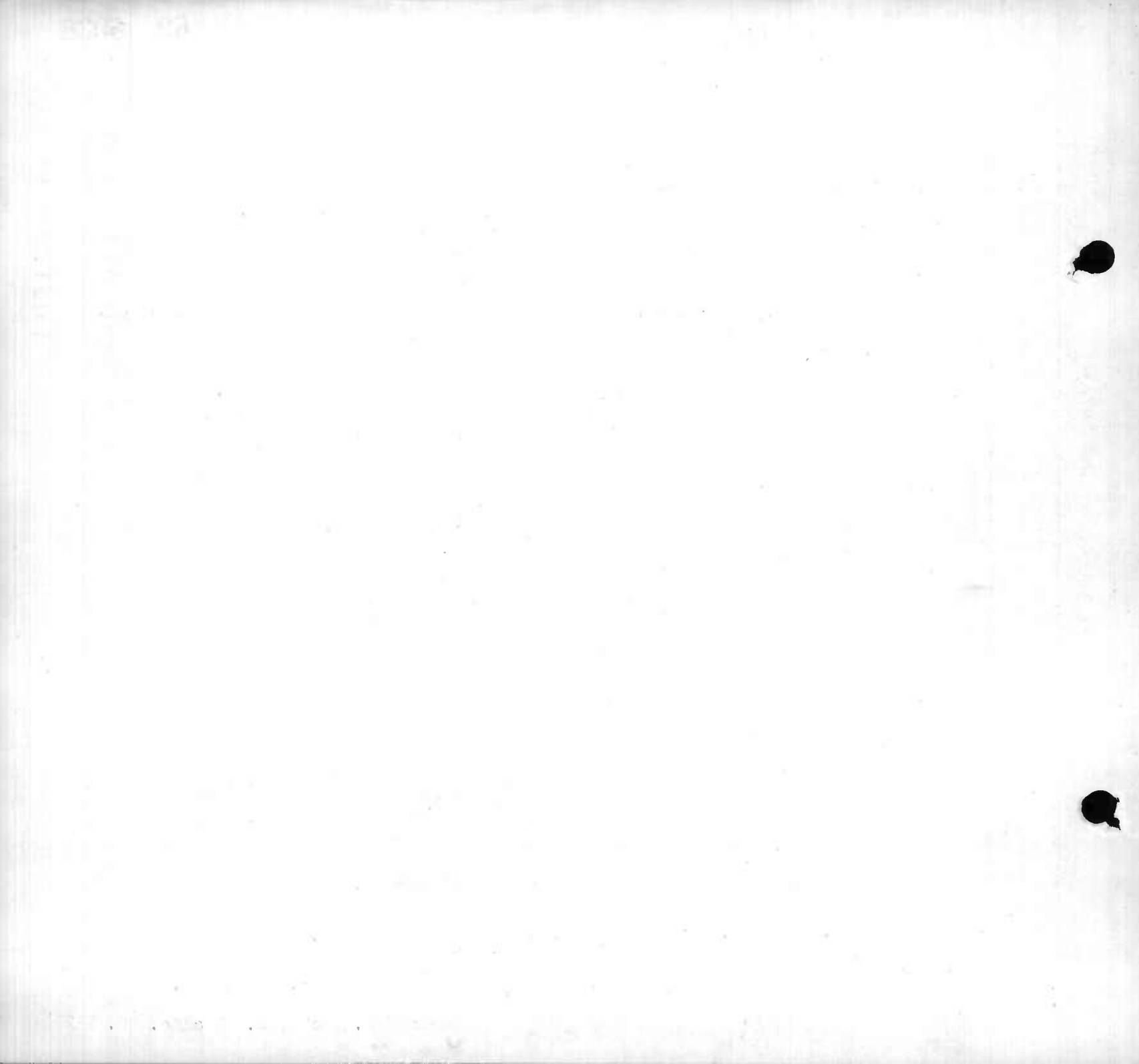
Puerto Rico 69 6937		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6937	
BIRTH NO. (Solange Rosa-Bruno)		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Solange B. Rosa		2. DATE AND HOUR OF DEATH 7/8/69 3:35 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		A. STATE PUERTO, RICO		B. COUNTY ✓ 49	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN HATO REY, FLORAL PARK		D. INSIDE CITY LIMITS? No <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER #XXX 371 PEDRE RUFO ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-66	9. AGE (In years last birthday) 2	If Under 1 Yr. Menstr. Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Puerto Rico	
12. CITIZEN OF WHAT COUNTRY? Puerto Rico		13. FATHER'S NAME CLUZ ROSA		14. MOTHER'S MAIDEN NAME MERCEDES BRUNO	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Mercedes B Rosa	
				ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE ① heart failure DUE TO, OR AS A CONSEQUENCE OF: (B) Tetralogy of Fallot DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 hrs. all life	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3 7/7/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tetral. of Fallot		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 1969 to July 8 1969 that (I) (we) last saw the deceased alive on July 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. F. Reale M.D.		23B. DATE SIGNED 7/8/69		23C. PHYSICIAN'S NAME (Type) V. F. REALE M.D.	
		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/69		24C. NAME OF CEMETERY or CREMATORY Manati Cemetery	
24D. LOCATION Manati, Puerto Rico		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruick Inc.		25D. ADDRESS Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 69 6938					REG. NO. 69 6938					
1. NAME OF DECEASED (Type or Print) Lloyd H. Hemmick					2. DATE AND HOUR OF DEATH July 8, 1969					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2702					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 The Union Memorial Hospital					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER 4632 Walther Blvd.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-1901	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-printer				10B. KIND OF BUSINESS OR INDUSTRY Balto. Stationary		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas L. Hemmick				14. MOTHER'S MAIDEN NAME Mary Elizabeth Herpel						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-01-8698		17. INFORMANT ADDRESS Emily (nee Lotz) Hemmick (wife)				
18. 412-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cor pulmonale (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Arterio-sclerotic vas. Heart Dis. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					2 yrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan 21 1969 to June 24 1969 , that (I) was lost saw the deceased alive on June 24 1969 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Carl F. Benson M.D.					23B. DATE SIGNED July 8, 1969			23C. PHYSICIAN'S NAME (Type) Dr. Carl F. Benson M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7-11-69		24C. NAME OF CEMETERY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969			25B. NAME OF REGISTRAR Philip E. Taylor, M.D.			25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck Inc. B. Balto. Md. 21214				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6939	
BIRTH NO. 69 6939		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH July 8th, 1969 4:10 A.M.	
1. NAME OF DECEASED (Type or Print) MILLER WILLIAM J.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			
CERTIFICATE AMENDED		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-17-07 9. AGE (in years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME GEORGE MILLER		14. MOTHER'S MAIDEN NAME JULIE SCHOEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 205-05-9396		17. INFORMANT ADDRESS MRS. MARGARET L. MILLER SAME AS ABOVE	
18. 41019 SS# 215-05-9396		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6/3/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY FAILURE		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE, 13 19 69 to July, 8th 19 69 that (I) (we) last saw the deceased alive on July 8th 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE CARRER J. Calum V. M.D.		23B. DATE SIGNED July 8th, 1969			
23C. PHYSICIAN'S NAME (Type) CARRERA, JUAN M. M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/69		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck, Inc. Balto. Md. 21214	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					

Social Security Card furnished by widow

7-16-69 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6940				CITY HEALTH DEPARTMENT		REG. NO. 69 6940	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Brack, GEORGE L		July 8 th 1969 9 ¹⁵ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
Union Memorial Hospital 44				Maryland		102	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				85 DECKER AVENUE 21224			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/3/14	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
MECHANIC				American Brewery		54	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
MARYLAND				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN George A. Brack				MARY ELIZABETH UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
UNKNOWN No				218-07-3660		Mrs Myrtle Brack Same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
162.1 I				Pneumonia			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Bronchogenic Carcinoma			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Acute renal failure			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
				Y.S			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				<input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/3 1969 to July 8 th 1969 that (I) (we) last saw the deceased alive on July 8 th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. Cabrera V. M.D.				July 8 th 1969			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CABRERA, JOAN M. M.D.				UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/11/69		Oak Lawn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 10 1969		Robert E. Taylor M.D.		John A. Moran, Inc.		3000 E. Baltimore St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **69 6941**

BIRTH NO. **67-02850-69 6941**

1. NAME OF DECEASED (Type or Print) KATHY HARTMAN		2. DATE AND HOUR OF DEATH JULY 7, 1969 4:26 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GEN. HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2505 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3604 WEST BAY AVENUE	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 5 1967
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 2 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) UNITED STATES		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME EDWARD HARTMAN		14. MOTHER'S MAIDEN NAME JEAN COLEMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward Hartman		ADDRESS 3604 West Bay Ave 21225	

18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hereditary Premature		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hereditary Premature		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-6-69 19 to 7-7-69 19, that (I) (we) lost the deceased alive on 7-7-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Estrellita P. Trias M.D.				23B. DATE SIGNED 7-7-69	
23C. PHYSICIAN'S NAME (Type) ESTRELLITA P. TRIAS M.D.				23D. ADDRESS SOUTH BALTIMORE GEN. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/69		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	
24D. LOCATION Gov Ritchie Hwy		24E. ADDRESS AA Co Md		24F. ADDRESS Gov Ritchie Hwy	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Jarboe M.D.		25C. FUNERAL DIRECTOR Mr. Billy A.H. V37 Potomac Ave	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>George A. DAHM</u> <u>GEORGE DAHM</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Agnes Hospital</u>		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour	M.	
				July	8,	1969	2:15 a	M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u>		C. CITY OR TOWN <u>Balto. Co.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
6. SEX <u>Male</u>	7. RACE <u>White</u>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
9. DATE OF BIRTH <u>7-22-86</u>		10. AGE (In years lost birthday) <u>83</u>		E. STREET AND NUMBER <u>Little Sister of the Poor 601 Maiden Choice Lane</u>				
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lane</u>				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk Court House</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <u>Hospital Records - Above</u>				
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u>		CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
		(B) DUE TO, OR AS A CONSEQUENCE OF:						
		(C) DUE TO, OR AS A CONSEQUENCE OF:						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Healing burns of 15% of the body surfaces						
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) <u>no</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Convent</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>601 Maiden Choice Lane</u>				
22D. TIME OF INJURY (APPROX.) 6 4 69 5:10 p		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Subject dropped cigarette on clothes setting self on fire</u>				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. EXAMINER'S NAME (Type) <u>Werner U. Spitz M.D.</u> Deputy Chief Medical Examiner 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>7-10-69</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1969</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR <u>Baroness</u> ADDRESS <u>Severna Pk</u>								

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VALLEY PATENT

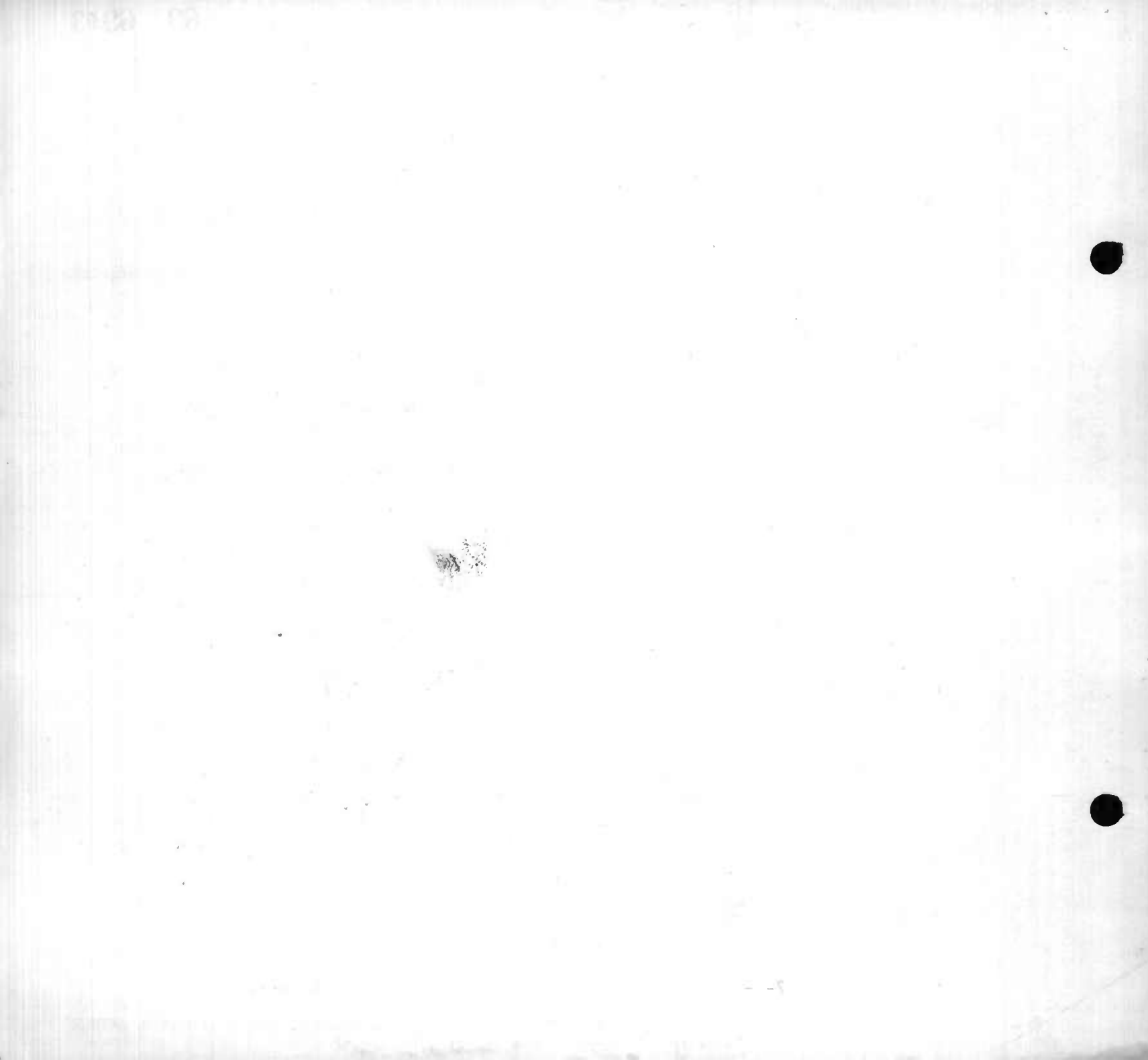
U.S. PATENT

ALFRED W. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 6943		69 6943		69 6943	
1. NAME OF DECEASED (Type or Print) JOHN A. BANASKY			2. DATE AND HOUR OF DEATH 7/6/69 12:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2636		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL 48			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12-7-04		9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY GUARD			11. BIRTHPLACE (State or foreign country) ARKANSAS		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN BANASKY			14. MOTHER'S MAIDEN NAME ANNA PROTAR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-07-1217		17. INFORMANT HOSPITAL ADMISSION SHEET
18. 195.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ABDOMINAL CARCINOMATOSIS CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wk.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/2/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Emergency		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 69 to 7/6 19 69 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karl R. Meck, Jr. M.D.				23B. DATE SIGNED 7/6/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-1969		24C. NAME OF CEMETERY or CREMATORY St Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 10 1969			
25A. NAME OF REGISTRAR Robert E. Taylor, M.D.		25B. FUNERAL DIRECTOR WALTER DABROWSKI		25C. ADDRESS 100 5 DUNDALK AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 6944

BIRTH NO. 69 6944		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6944	
1. NAME OF DECEASED (Type or Print) Ethel Hamilton			2. DATE AND HOUR OF DEATH 7/7/69 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Mem. Hosp.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1207		
5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/27/08 9. AGE (In years last birthday) 61		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid			11. BIRTHPLACE (State or foreign country) Md.		
10B. KIND OF BUSINESS OR INDUSTRY Hotel			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Sylvester Hamilton			ADDRESS 2649 Miles Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Widespread metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (As discussed with medical examiner) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/7 6/24 19 67 to 7/7 1969 and that (we) lost saw the deceased alive on 7/7 1969 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman Brecher M.D.				23B. DATE SIGNED 7/9/69	
23C. PHYSICIAN'S NAME (Type) HERMAN BRECHER M.D.				23D. ADDRESS 443 E. 25th St Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/69		24C. NAME of CEMETERY or CREMATORY Lake View Mem.	
24D. LOCATION (City, town, or county) Balto. Co.		24E. DATE REC'D BY HEALTH DEPT. JUL 10 1969		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR Paul E. Chenoweth Jr.		24H. ADDRESS 3617 Chestnut Ave.		24I. DATE 7/10/69	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. **69 6945**

BIRTH NO. 69 6945		1. NAME OF DECEASED (Type or Print) Jessie B. Thornton		2. DATE AND HOUR OF DEATH 6 July 1969 3:40^{PM}	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1703	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Mt. Sinai Nursing Home Inc 4613 Park Heights Ave Balt, Md		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY SPARROWS POINT		8. DATE OF BIRTH 10-3-1901 9. AGE (In years last birthday) 67	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FOUNTAIN	
14. MOTHER'S MAIDEN NAME MATTIE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-5742	
17. INFORMANT ESTELLE THORNTON - SAME		ADDRESS			
18. 410.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic + Hypertensive Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension + Renal Failure (C) etiology unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 3 mos 5 yrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). a) Gout b) Anemia 2° to Uremia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 30 June 1969 to 6 July 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6 July 1969 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Henry J. Babitt, MD DEGREE				23B. DATE SIGNED 6 July 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 4607 E. Pen Lucy Rd Balt, Md 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-69		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.	
24D. LOCATION (City, town, or county) BALTO. Md.		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR G. R. BAILEY ADDRESS KELSON F. H. 1348 N. CANTOWN ST.	



0.416

69 6946

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6946

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WARREN OLIVER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 7, 1969 1:15 p.m.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1538	
6. SEX Male	7. RACE Colored	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2-8-51		10. AGE (In years lost birthday) 18	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 3411 Liberty Heights Ave.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Oliver Sr.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Emma	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT Edward Oliver Jr.	
				ADDRESS 4105 Rolandview	
19. E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of the left chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7-11-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Food Market		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? M & H Food Market	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 7 7 69 1:00		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject shot during attempted hold-up	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED July 8, 1969					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-69		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Jarboe, M.D.	
				25C. FUNERAL DIRECTOR V.H. ADDRESS Kelson F.H. 1348 Calhoun St.	

2189 68

area 22

ACADEMY BUILDING

RECORDS

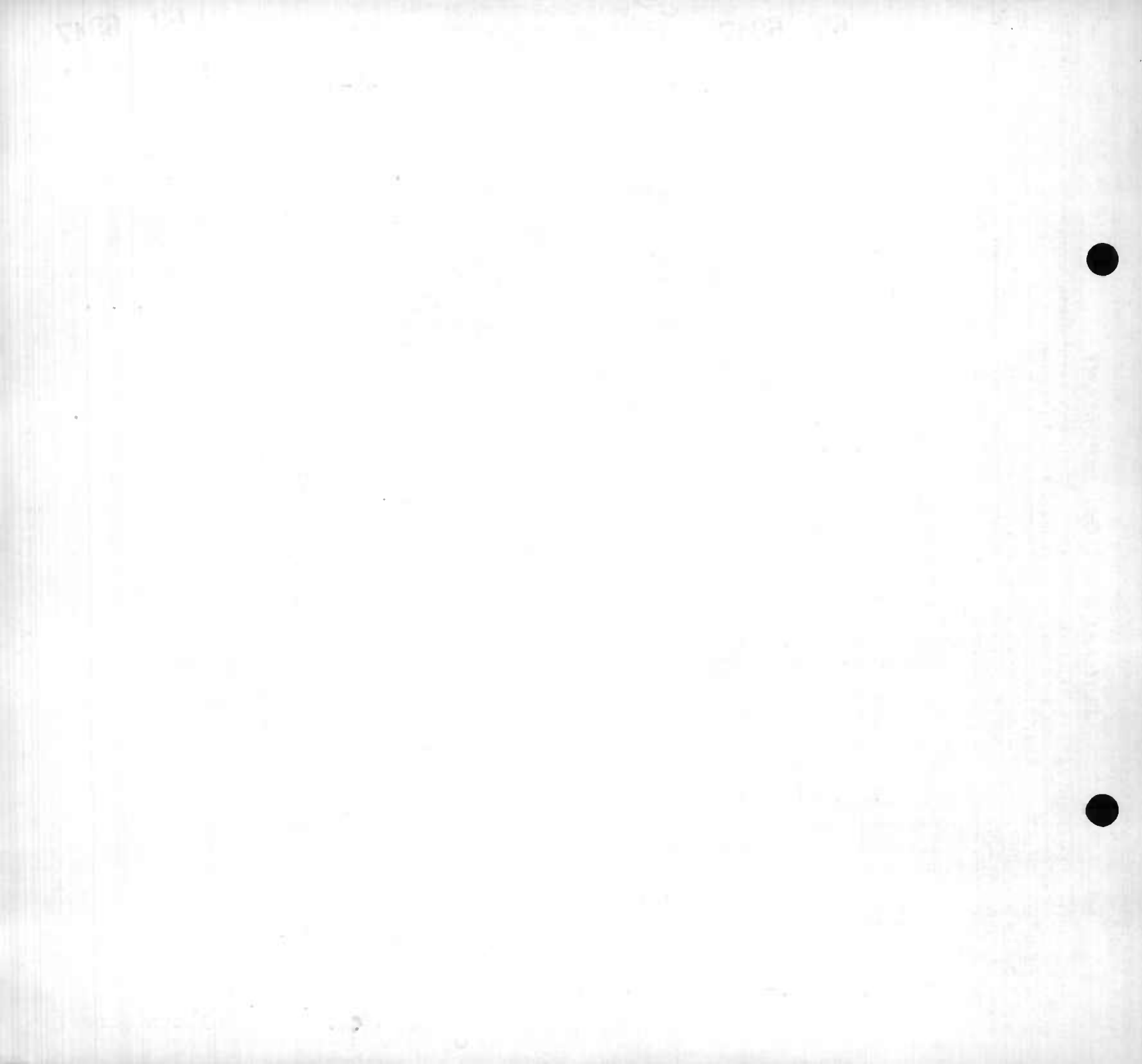
WILSON

230

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

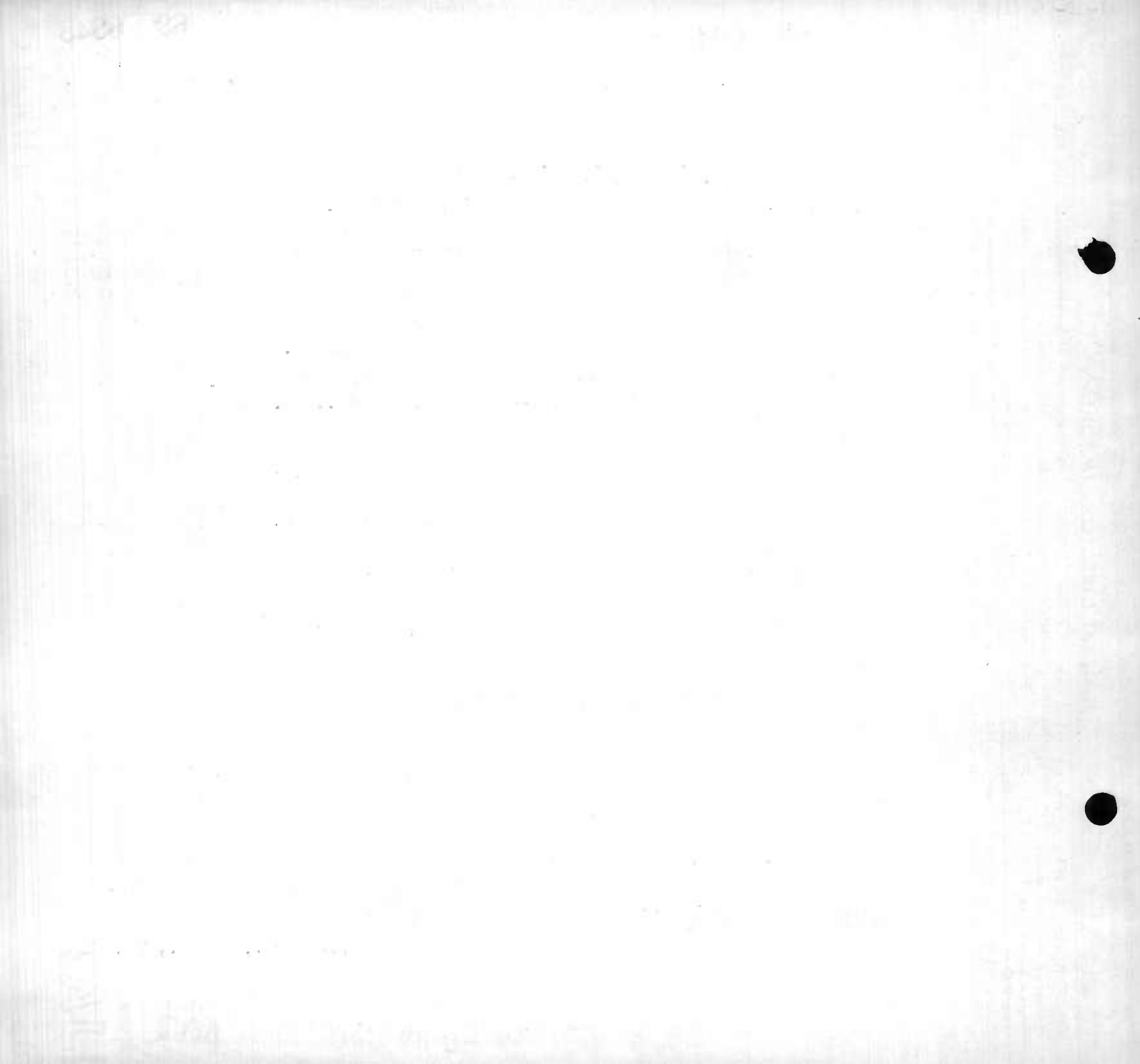
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6947	
<div style="display: flex; justify-content: space-between;"> 69 6947 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Blanche E. Mason		7-7-69	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital			A. STATE Maryland		
			8. COUNTY 1608		
			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1020 Augusta Avenue		
5. SEX Female	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-89	9. AGE (In years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Virginia	
13. FATHER'S NAME Benjamin Clark			14. MOTHER'S MAIDEN NAME Julia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Marcus Mason 1020 Augusta Ave.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardio-vascular disease</i> 1965 (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>7-16 1965</u> to <u>7-7 1969</u> , that (I) (we) last saw the deceased alive on <u>3-24 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas W. Harris, MD</i>				23B. DATE SIGNED 7-8-69	
23C. PHYSICIAN'S NAME (Type) THOMAS W. HARRIS, MD				23D. ADDRESS 4200 EDMONDSON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-11-69		Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county)		24E. STATE			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 10 1969		Robert E. Taylor, M.D.		V.R. Bailey	
				ADDRESS Kelson, F.H. 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

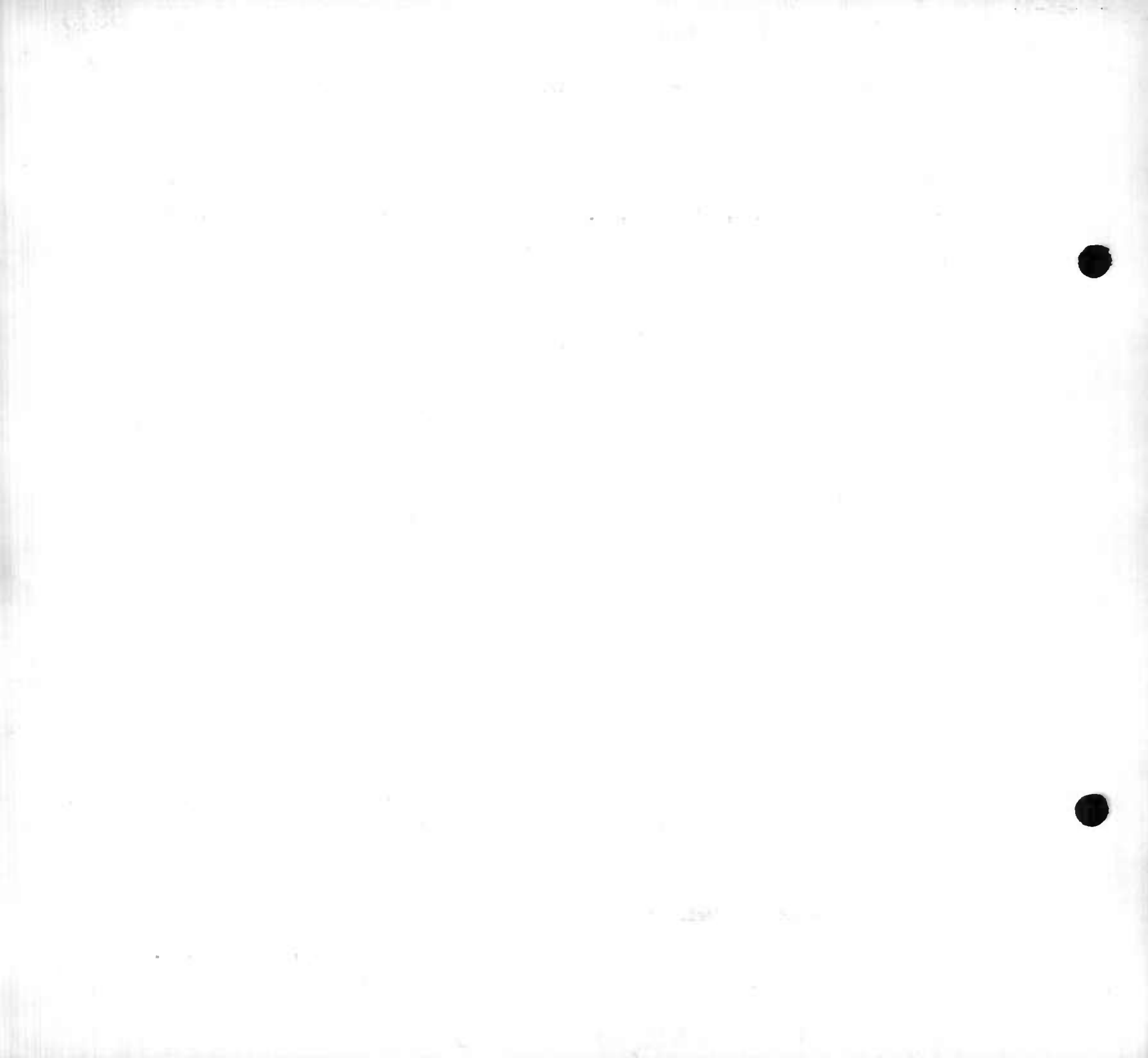
41-39-08 v1b		69 6948		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6948	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KURTZ, Louis		2. DATE AND HOUR OF DEATH JUNE 26, 1969 8 ¹⁰ /PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Ave., Balto., Md. 31 BALTIMORE CITY HOSPITALS 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 504 Lehigh St. 21224			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-31-97	9. AGE (In years lost ⁷¹ day)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis				14. MOTHER'S MAIDEN NAME Ella E.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-1197-A		17. INFORMANT 4940 Eastern Ave. Records: Balto., Md. 21224		ADDRESS	
18. 519.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIO-RESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: COR PULMONALE (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? 6/23/69 6/26 69			
22. I certify that (I) (this hospital) attended the deceased from 6/26 19 to 6/26 19, that (I) (we) lost saw the deceased alive on 6/26 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Torre M.D.				23B. DATE SIGNED 6-26-69			
23C. PHYSICIAN'S NAME (Type) JOSE TORRES M.D.				23D. ADDRESS BALTO. CITY HOSPITALS 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUL 8 1969		24C. NAME OF CEMETERY JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BEHD		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR John E. Taylor M.D.		25C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

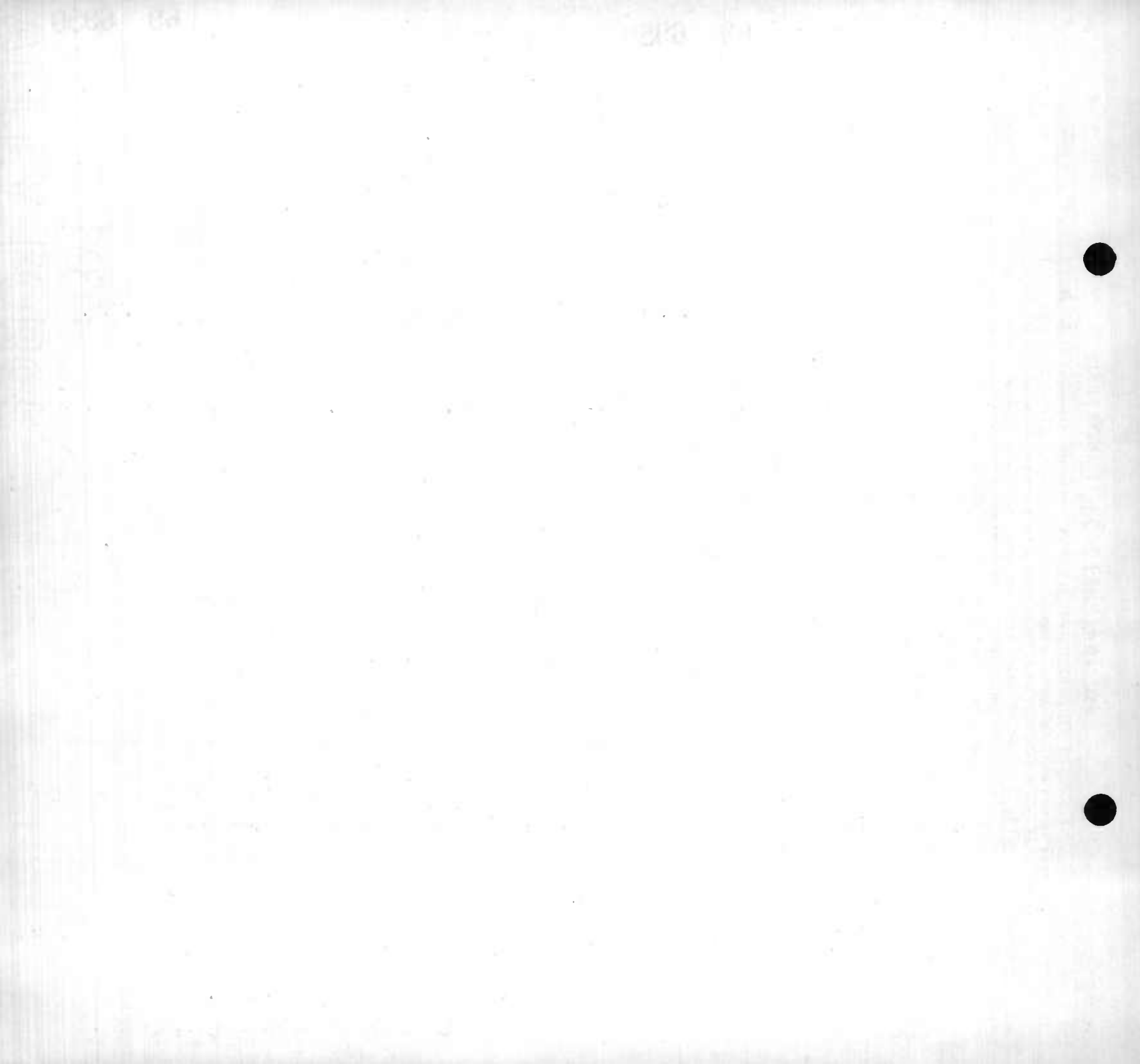
H-620 69 6949		BALTIMORE CITY HEALTH DEPARTMENT		69 6949	
BIRTH NO. 69-11847		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Harris B.B. - Patricia Ann</u>		2. DATE AND HOUR OF DEATH <u>7-4-69</u> <u>1 30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baets City Hospitals</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>2037</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Avenue, Baltimore, Md. 21224</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>404 Lynhurst Street</u>		21229			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-69</u>	9. AGE (In years last birthday) <u>4</u>	10. CITIZEN OF WHAT COUNTRY <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>new-born</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Harris</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Ann Harris</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Records: BCH-4940 Eastern Avenue</u>	
				ADDRESS <u>21224</u>	
18. <u>776.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>birth 6/30</u> 19 <u>69</u> to <u>7/4</u> 19 <u>69</u> and that (I) (we) last saw the deceased alive on <u>7/4</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature] MD</u>		23B. DATE SIGNED <u>7-4-69</u>		23C. PHYSICIAN'S NAME (Type) <u>Otto Teixeira</u>	
23D. ADDRESS <u>B.C. Hospitals</u>		23E. ADDRESS <u>4940 Eastern Avenue, Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>7-8-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE CITY HOSPITALS</u>	
24D. LOCATION <u>4940 EASTERN AVENUE, BALTO. MD.</u>		24E. LOCATION <u>21224</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
10/5-255 69 6950				69 6950	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) CHARLES SCHUCKMAN			2. DATE AND HOUR OF DEATH 7/8/69 7:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 00			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4405 Old Frederick Road			E. STREET AND NUMBER 4405 Old Frederick Road		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1897	9. AGE (In years last birthday) 71	11. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Mail			10B. KIND OF BUSINESS OR INDUSTRY U.S. POST OFFICE		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George H. Schuckman		
14. MOTHER'S MAIDEN NAME Elizabeth Heinz			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI-4/12/17-6/5/19		
16. SOCIAL SECURITY NO. --			17. INFORMANT Mrs. Charles G. Schuckman, 4405 Old Frederick Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 154.2) I (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinomatosis, general 3 mos.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE Adenocarcinoma, anal canal 3 years (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 21, 1969 to July 8, 1969 , that (I) (we) last saw the deceased alive on July 8, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Gilbert E. Rudman, M.D.				23B. DATE SIGNED 7/10/69	
23C. PHYSICIAN'S NAME (Type) GILBERT E. RUDMAN, M.D.				23D. ADDRESS 2517 W. BALTO - ST., BALTO, MD 21223	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/69		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME of REGISTRAR Robert E. Taylor, R.D. 9		24F. FUNERAL DIRECTOR Wigke, 4101 Edmondson Ave., 21229	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D. 9		25C. FUNERAL DIRECTOR Wigke, 4101 Edmondson Ave., 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 6951

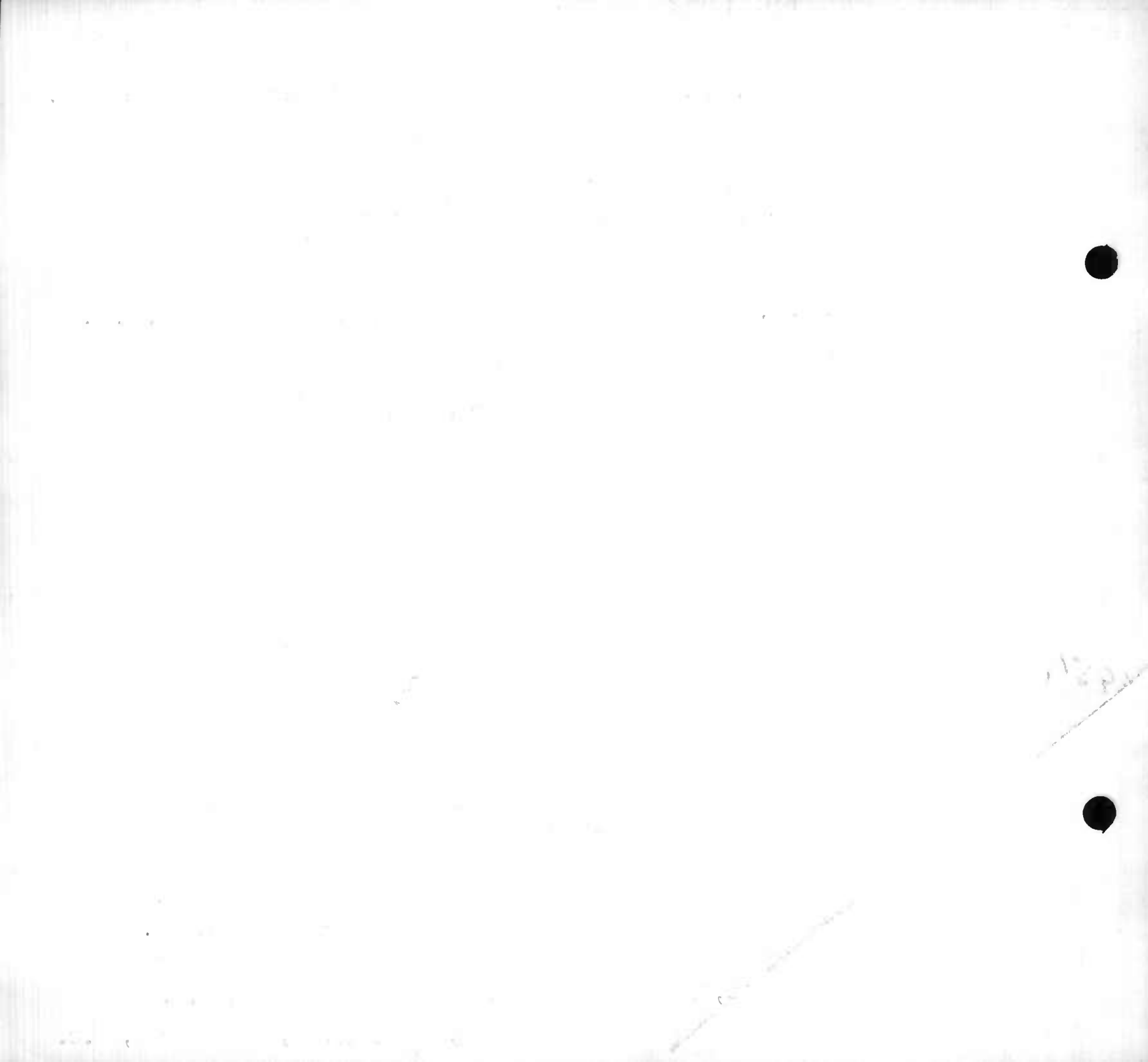
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH69 6951
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GORDON, BESSIE FANN		2. DATE AND HOUR OF DEATH 7-4-69 10 25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1537		C. CITY OR TOWN BAITIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 4-3 GOOD SAMARITAN HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3119 MONDOWMIN AVE 21216		5. SEX F 6. RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-98 9. AGE (In years lost birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Gordon		14. MOTHER'S MAIDEN NAME ROSIE FAUNTLEROY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217030340		17. INFORMANT Ruth Allen, 3121 Mondowmin Ave.	
18. 189.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac and Respiratory arrest (B) Uremia - DUE TO, OR AS A CONSEQUENCE OF: (C) Transitional Cell Ca of Rt Kidney		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 06-06-1969 to July 4th 1969 , that (I) (we) last saw the deceased alive on July 4th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Semerdjian M.D.		23B. DATE SIGNED 4th July 1969		23C. PHYSICIAN'S NAME (Type) Grant Semerdjian M.D.	
23D. ADDRESS Johns Hopkins Hosp		23E. ADDRESS 601 N. Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-21-69		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Baltimore, Maryland		24E. LOCATION Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

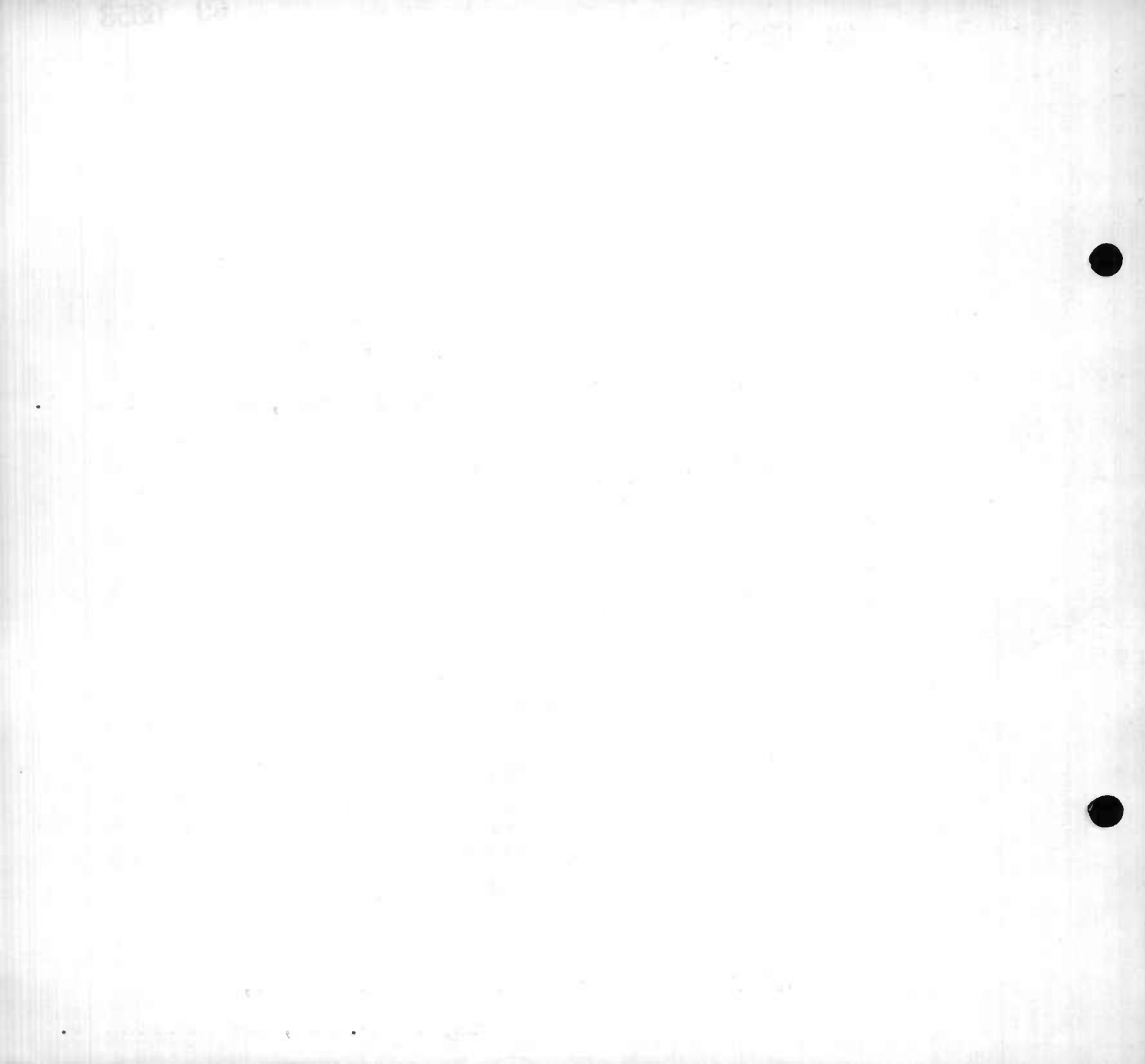
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6952	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alford, Olin		7-5-69 11:00 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			Maryland 2037		
5. SEX			6. DATE OF BIRTH		7. AGE (In years lost birthday)
Male			2-3-16		53
8. RACE			9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Negro					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Retired I. L. A.					South Carolina
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
Willie Alford			Rachel Monltrie		U. S. A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			249-19-6730		Mrs. Viola Alford Same
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
[This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.]				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				Renal Failure 6-30/69 at 4:00 PM	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertensive Cardiovascular Disease 7-5/69 at 11:00 AM	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-30-69 19 to 7-5-69 19 that (I) (we) last saw the deceased alive on 7-5-69 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Raymundo R. Corpuz, M.D.				7-5-69	
23C. PHYSICIAN'S NAME (Typel)				23D. ADDRESS	
Raymundo R. Corpuz, M.D.				Provident Hospital, Inc. 1514 Division Street - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		July 10, 69		st Stevens Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 10 1969		J. C. Taylor, M.D.		Magidson & Son, Georgetown, S.C.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6953	
BIRTH NO. 69 6953				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY BLANCHE FREDERICK			2. DATE AND HOUR OF DEATH 7/7/69 11 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 8 UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 402		
5. SEX FEMALE			6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JOHN FREDERICK			14. MOTHER'S MAIDEN NAME NATILDA BUTLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Robert Frederick, 911 Whitelock St.
18. 250-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE CHRONIC RENAL DISEASE (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: (C) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS 4 YEARS ?
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/6 19 69 to TIME OF DEATH 19 , that (I) (we) last saw the deceased alive on 7/7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marcia C. Schneider M.D.				23B. DATE SIGNED 7/7/69	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS Charles R. Law, 802 Madison Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/69		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR James E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6954	
BIRTH NO. 69 6954		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Adam William Kaczorowski			2. DATE AND HOUR OF DEATH July 9, 1969 1 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 105 South Wolfe Street At Home			A. STATE Maryland B. COUNTY 201		
			C. CITY OR TOWN Baltimore, 21231		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 105 South Wolfe Street		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1909	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eastern Venetian Blinds			11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Kaczorowski			14. MOTHER'S MAIDEN NAME Theresa Wilczynski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 221-01-0876	17. INFORMANT ADDRESS Mrs. Eva Cichorz 105 South Wolfe Street		
18. 436.0 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: Hypertension		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1966 to July 9, 1969 , that (I) (we) last saw the deceased alive on July 7, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Israel J. Feinglos DEGREE				23B. DATE SIGNED 7/9/69	
23C. PHYSICIAN'S NAME (Type) Israel J. Feinglos			23D. ADDRESS 2002 E. Pratt Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/69		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR James E. Sawyer, M.D.		25C. FUNERAL DIRECTOR ADDRESS George A. Weber 705 South Ann	

69 6955

BALTIMORE CITY HEALTH DEPARTMENT

69 6955

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LUCILLE SHORTS CONYERS

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July

8

1969 6:45 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1802

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

Colored

WIDOWED ☐ DIVORCED ☐

Balto.

YES ☒ NO ☐

9. DATE OF BIRTH

5/25/33

10. AGE (In years

36

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1022 W. Saratoga St.

11. BIRTHPLACE (State or foreign country)

Summerton, S. C.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES WITHERSPOON

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

ETHEL WITHERSPOON

1708 Guilford Ave.

19. 571.8 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Fatty alteration of the liver

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner July 8, 1969

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/12/69

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 10 1969

25B. NAME OF REGISTRAR

J. E. Taylor, M.D.

25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOMES, INC.

ADDRESS

1701-31 Laurens Street, Balto., Md. 21217

0000

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0000

00

RECEIVED BY THE OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

DATE: 10/10/60

TO: THE SECRETARY OF THE ARMY

FROM: THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

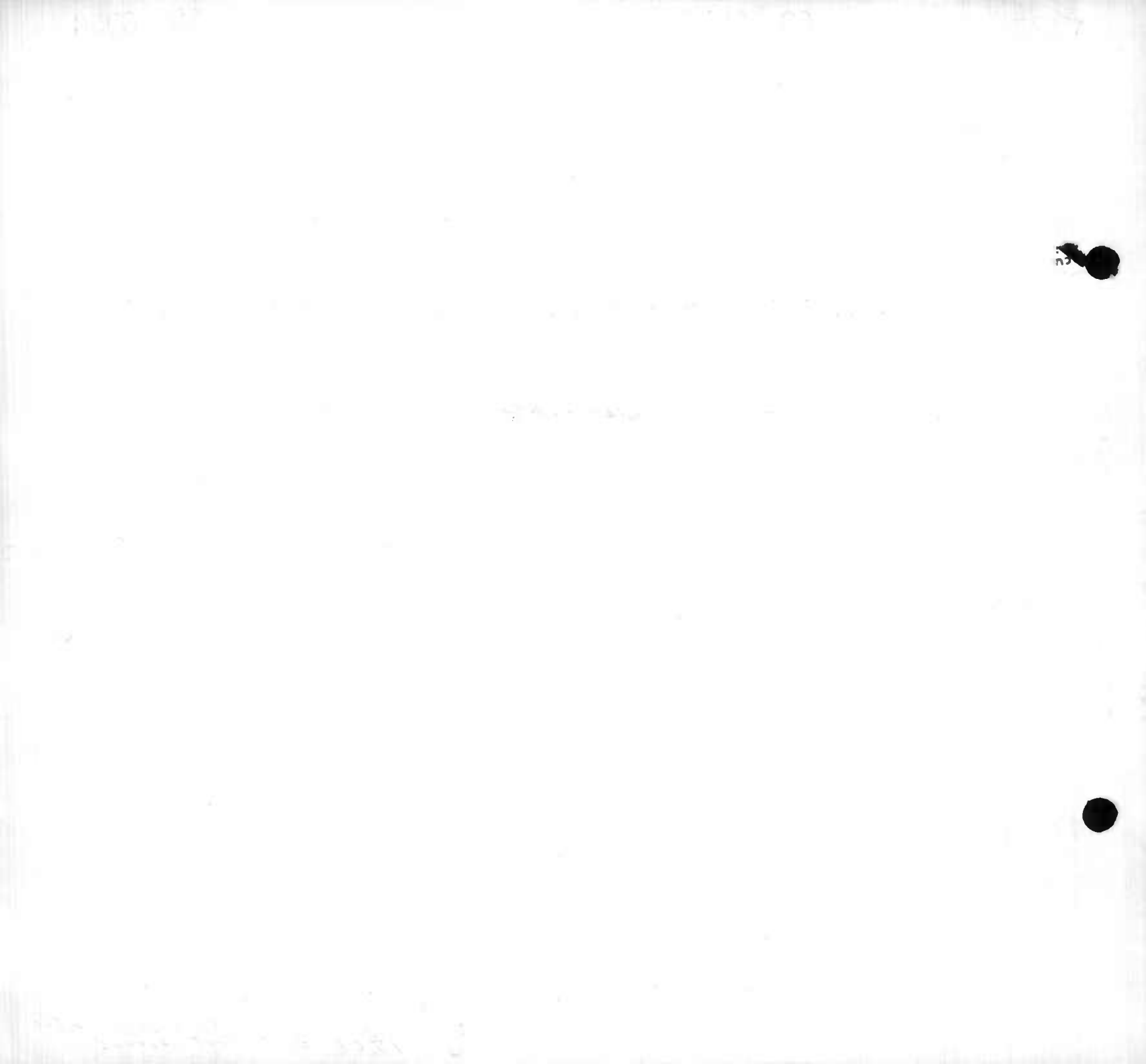
69 6956

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 6956

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Christina Kane</u>		2. DATE AND HOUR OF DEATH <u>5-July-69</u> <u>11040</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>21230</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u> <u>43</u>				E. STREET AND NUMBER <u>1445 Reynolds St</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26-Nov-02</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tearson & Grace Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John I. Gunning</u>			
14. MOTHER'S MAIDEN NAME <u>Augusta Hrubes</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-20-7988</u>		17. INFORMANT <u>Mrs Marie Kehs (daughter)</u> ADDRESS <u>Same</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>250.91</u> <u>Arteriosclerotic Cardio-vascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes mellitus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>18 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>5-July (12PM)</u> 19 <u>69</u> to <u>5-July (1040PM)</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>5-July</u> 19 <u>69</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard E Fisher M.D.</u>				23B. DATE SIGNED <u>5-July-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard E Fisher M.D.</u>				23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7/9/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles E. Stevens Funeral Home, Inc.</u>			
25D. ADDRESS <u>601806 East Port Avenue</u>					



J-552 69 6957
CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE JENNINGS

2. DATE AND HOUR OF DEATH

JUNE 11, 1969

5:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 BALTIMORE CITY HOSPITALS

4940 EASTERN AVE. BALTO. MD. 21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

2226 NORTH CALVERT STREET 21202

D. INSIDE CITY LIMITS?

YES ☒NO ☐

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-13-14

9. AGE (In years
last birthday)

55

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY

Disability

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ED JENNINGS

14. MOTHER'S MAIDEN NAME

ELLA

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

249-20-0354

17. INFORMANT

ADDRESS

21224

BCH: RECORDS 4940 EASTERN AVE. BALTO. MD.

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY ARREST

MIN.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CURCINOMIA OF LUNG

? MONTHS

(C)

DUE TO, OR AS A CONSEQUENCE OF:

PULMONARY TBC

YEARS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

HASCVD

YEARS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 15 19 69 to JUNE 11 19 69,
that (I) (we) last saw the deceased alive on JUNE 10 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph Kaplan

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/11/69

23C. PHYSICIAN'S
NAME (Type)

JOSEPH KAPLAN

DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL

6/14/69

PINE LAWN

ANNAPOLIS, MD

25A. DATE RECD. BY HEALTH DEPT.

JUL 10 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

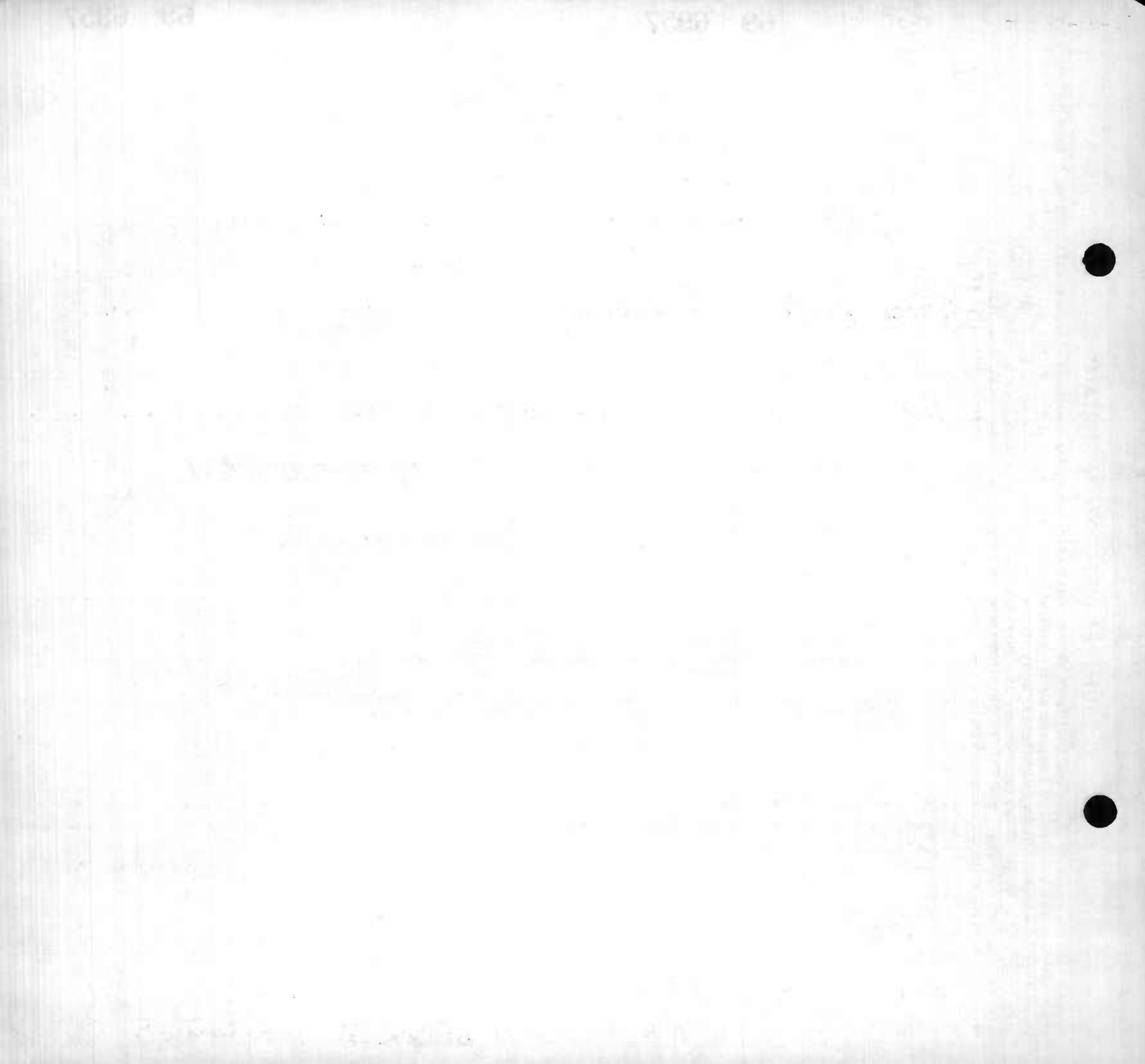
J. B. Johnson

ADDRESS

1900 Eutaw Pl Balto. Md

FUNERAL DIRECTOR: IMPORTANT

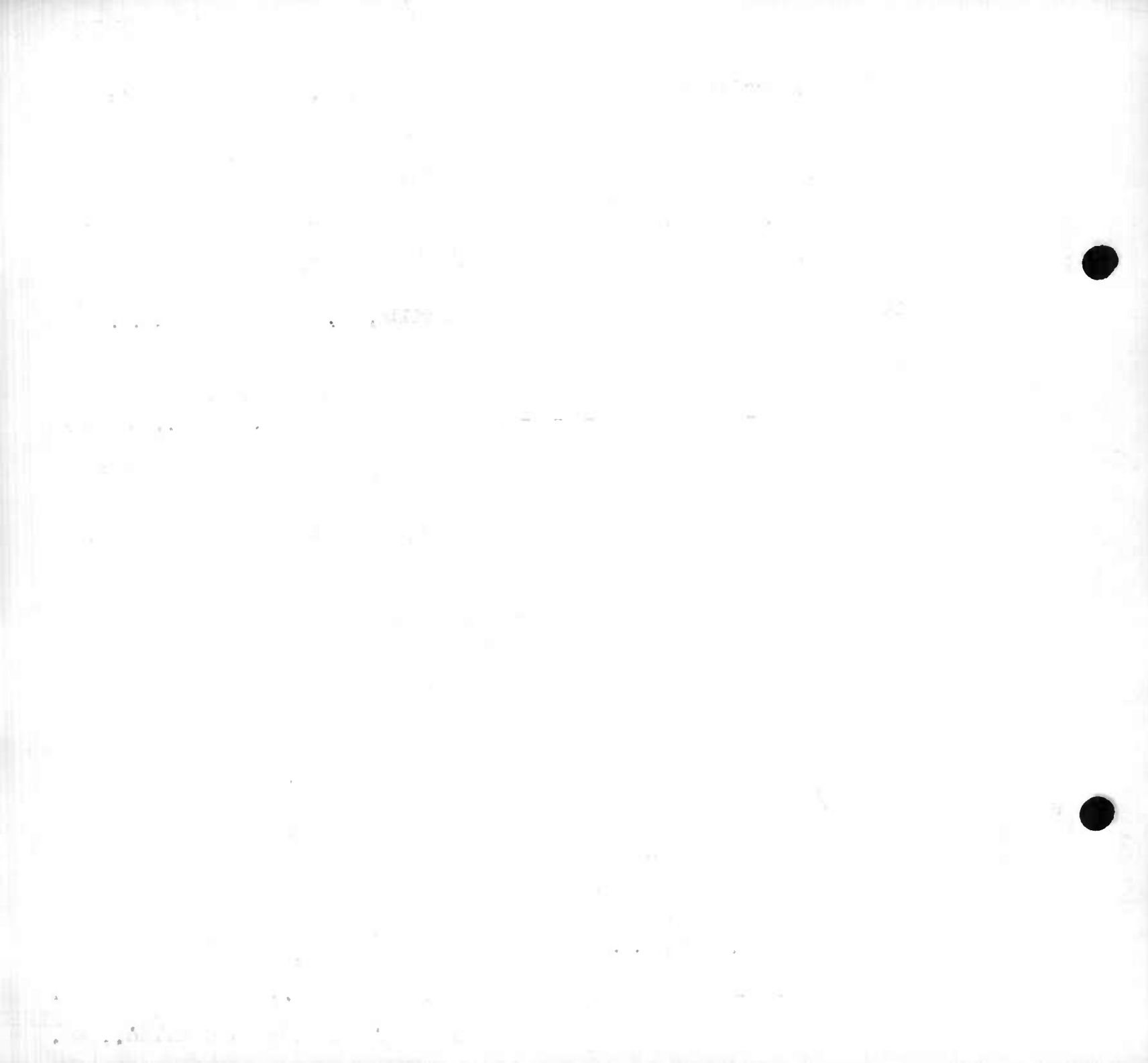
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

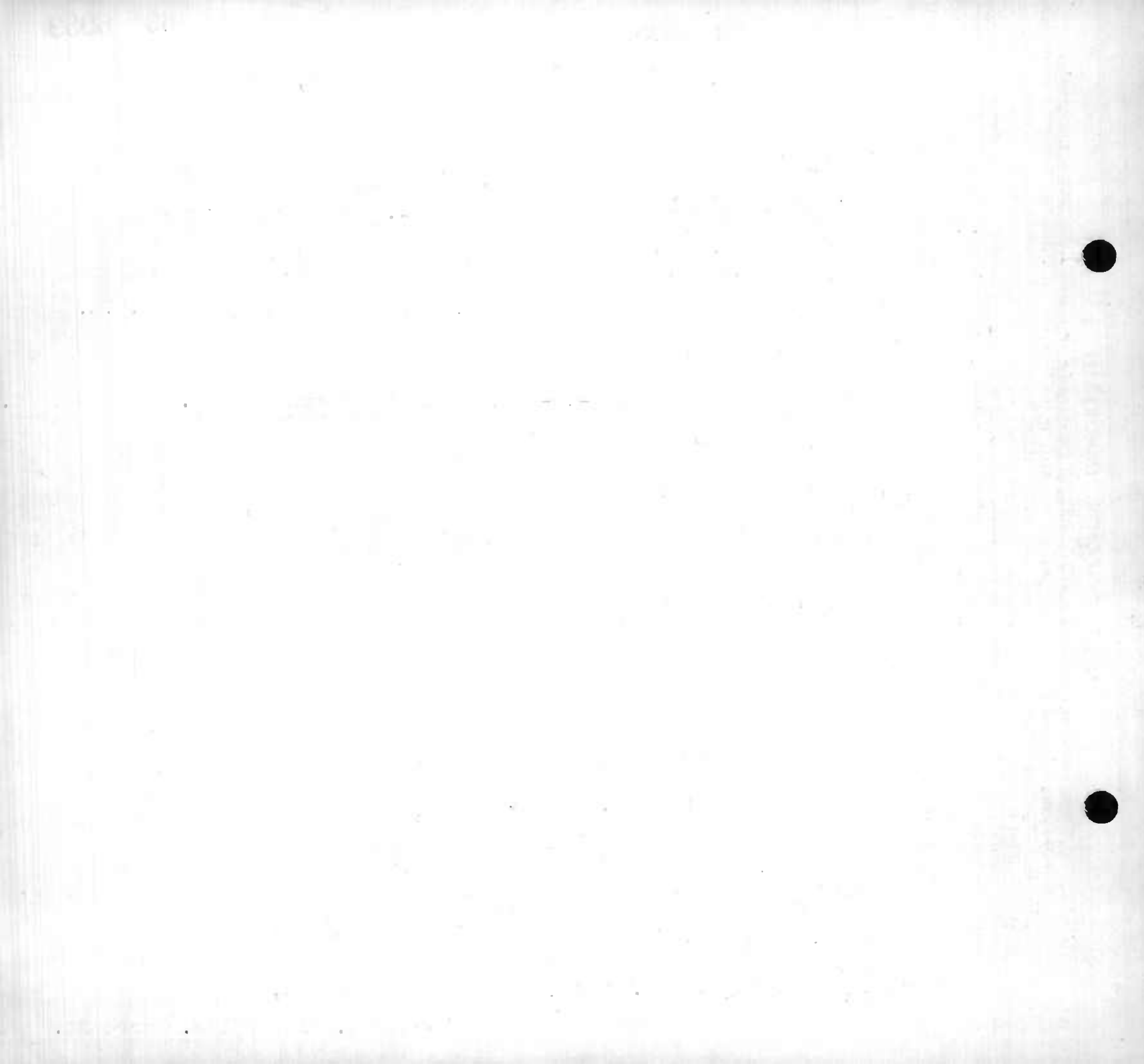
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-324		69 6958		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6958	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) STIGALL, Archer Lee				July 9, 1969 12:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Maryland			
5. SEX				6. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		12/21/87		81	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Civil Engineer				Retired		Danville, Va.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Stigall				Martha Vaden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 4/20/17 - 11/23/18				218-09-90-86		VA Hospital Records 3900 Loch Raven Blvd., Balto Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				Pneumonia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				Arteriosclerotic heart disease			
				DUE TO, OR AS A CONSEQUENCE OF:			
				14 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Chronic bronchitis Emphysema			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from June 30th 19 69 to July 9th 19 69 that (1) (we) last saw the deceased alive on July 9th 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
YOUNG E. CHUN, M.D.				3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-11-1969		Baltimore National		Balto., Md.	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 10 1969		Robert E. Talley, M.D.		Henry W. Jenkins & Sons Co.		21218 York Road Balto., Md.	



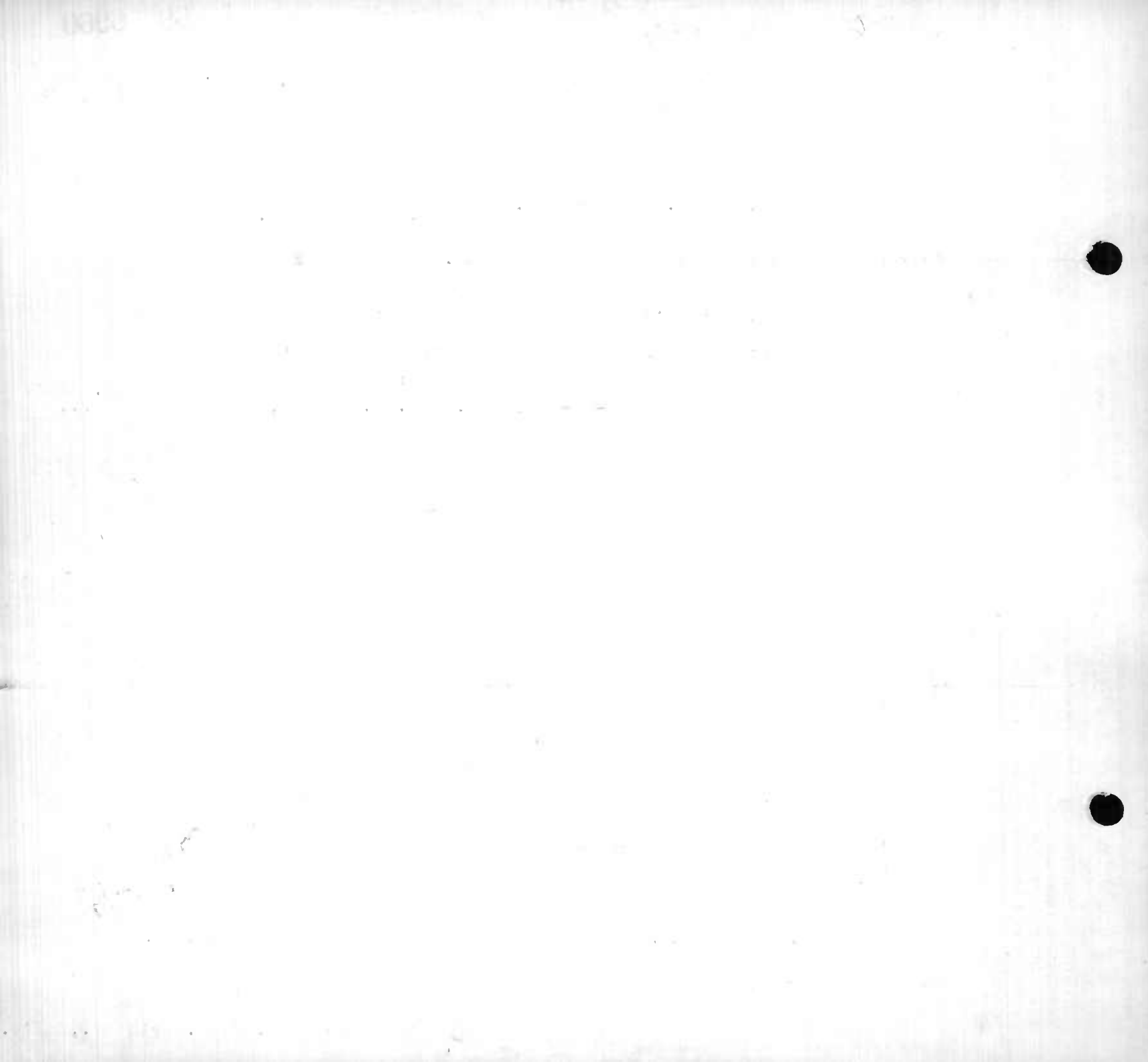
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
69 6959 CERTIFICATE OF DEATH					REG. NO. 69 6959				
BIRTH NO. T-520					BIRTH NO.				
1. NAME OF DECEASED (Type or Print) JAMES R. THOMAS					2. DATE AND HOUR OF DEATH July 9, 1969 M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital					A. STATE Maryland		B. COUNTY 2002		
					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 2706 W. Baltimore Street				
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/25/99		9. AGE (In years last birthday) 69		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Horace Thomas					14. MOTHER'S MAIDEN NAME Katherine				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-09-1517		17. INFORMANT ADDRESS Estelle Thomas 2706 W. Baltimore St.				
18. I 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Respiratory Failure 30 days				
ANTECEDENT CAUSES					(B) 2° to Chronic Obstructive Pulmonary 20 years				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) Disease (Chronic Bronchitis & Emphysema)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from June 6 1969 to July 10 1969, that (I) (we) last saw the deceased alive on July 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Bernard S. Karpens Jr. M.D.					23B. DATE SIGNED July 10, 1969		23C. PHYSICIAN'S NAME (Type) BERNARD S. KARPENS JR. M.D.		
					23D. ADDRESS 514 Medical Arts Bldg, Balt., Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/69		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Arnold, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 661 W. Barre St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-363 69 6960		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6960	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARIAN FLORENCE STEWART		7-9-69 10 30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
		RESIDENCE: 101 W. Monument St.		Maryland 1102	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Remale		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housekeeper		Apts., Rectories		Aug. 1, 1885	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years lost birthday)	
William Elliott Barnhart		Martha Lake Johnston		83	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT: Sister	
NO		117-05-9621		ADDRESS Baltimore, Md. 21207	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.9 + 250.9		MYOCARDIAL INFARCTION		3 HRS.	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		RECURRENT CORONARY THROMBOSIS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		INITIAL EPISODE 3 HRS. AGO	
		(C) ATHERO SCLEROSIS			
II		DIABETES MELLITUS		9 YRS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 7 1965 to JULY 9 1969, that (I) (we) last saw the deceased alive on JULY 7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Carlton L. Sexton				7-9-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Carlton L. Sexton M.D.				819 Park Avenue Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		7/12/69		Highland Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 10 1969		RECEIVED		STEWART & MOWEN CO. 108 W. North Av., Balto.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6961	
BIRTH NO. B400				69 6961			
1. NAME OF DECEASED (Type or Print) Bell, FERN				2. DATE AND HOUR OF DEATH 7-6-69 10 15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY BALTIMORE			
C. CITY OR TOWN 5300				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 912 VIRGINIA AVENUE 21221							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-11	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, Give retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House-Wife						VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Shifflett				14. MOTHER'S MAIDEN NAME MABEL SHIFFLETT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 820-02-2025		17. INFORMANT ADDRESS RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
18. 430.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 7-6-69				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilateral aspiration pneumonia		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-27 1969 to 7-6 19 69 , that (I) (we) last saw the deceased alive on 7-6- 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Mehdi Sarkarati				23B. DATE SIGNED 7-6-69			
23C. PHYSICIAN'S NAME (Type) Mehdi Sarkarati				23D. ADDRESS B. City Hospital 4940 EASTERN AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/6/69		24C. NAME OF CEMETERY or CREMATORY Oak-Lawn	
24D. LOCATION (City, town, or county) Balto				(State) Md.			
25A. DATE RECEIVED BY HEALTH DEPT. JUL 10 1969				25B. NAME OF REGISTRAR 8-6-69 0000		25C. FUNERAL DIRECTOR ADDRESS 265 Connelly Sons - Esst Md.	

Called Hospital date of operation 7-3-69 CT.

James Whifflet
Horse W. 42

See 11-11-69

James Whifflet
Horse W. 42
See 11-11-69

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-220 BIRTH NO. 69-197869		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 6962	
1. NAME OF DECEASED (Type or Print) WOJCIK, BABY BOY "B"			2. DATE AND HOUR OF DEATH JULY 07, 1969 1:30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WILKENS & CATON AVENUES BALTIMORE MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY 5300 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1621 OLD EASTERN AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07 06 69	9. AGE (In years last birthday) 7	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. 7 6
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME EUGENE GEIGAN		
14. MOTHER'S MAIDEN NAME (WOJCIK) MARTINA			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 269.41 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hr			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 6, 19 69 to JULY 7, 19 69 that (X) (we) last saw the deceased alive on JULY 7, 19 69 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE John K. Weagley M.D.			23B. DATE SIGNED 8 July 1969		23C. PHYSICIAN'S NAME (Type) DR. JOHN WEAGLEY MD
23D. ADDRESS BALTIMORE MARYLAND ST AGNES HOSPITAL WILKENS & CATON AVE			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7/9/69			24C. NAME OF CEMETERY OR CREMATORY Morelands		
24D. LOCATION Balto.			25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Bernice Turner		
25D. ADDRESS 3044			25E. ADDRESS 3044		

EUGENE GEIGAN

Print 10/21 1921

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-220 69 6963		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 6963 4	
BIRTH NO. 69-11977		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WOJCIK, BABY BOY "A"		2. DATE AND HOUR OF DEATH JULY 07, 1969 2:20 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WILKENS & CATON AVENUES BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY 5300 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1621 OLD EASTERN AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07 06 69	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 7 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EUGENE GEIGAN		14. MOTHER'S MAIDEN NAME (WOJCIK) MARTINA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 769.4 I CAUSE OF DEATH DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Immaturity (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hr			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initialed medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 6, 19 69 to JULY 7, 19 69 that (X) (we) last saw the deceased alive on JULY 7, 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John K. Weagley MD		23B. DATE SIGNED 8 July 1969		23C. PHYSICIAN'S NAME (Type) DR. JOHN WEAGLEY M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/69		24C. NAME OF CEMETERY OR CREMATORY Mountlands	
24D. LOCATION Balto		24E. NAME OF REGISTRAR Robert E. Jaber, Jr.		24F. FUNERAL DIRECTOR Connelly Funeral Home	
24G. DATE REC'D BY HEALTH DEPT. JUL 10 1969		24H. NAME OF REGISTRAR		24I. ADDRESS Baltimore MD 21229	

Eugene Geigan

Received 7/9/68
Wm. Geigan

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6964	
BIRTH NO. R-534		69 6964 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RANDALL, Irene		2. DATE AND HOUR OF DEATH 6/30/69 - 5:45 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE Maryland B. COUNTY 1204 C. CITY OR TOWN Baltimore, Md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3018 22nd Street	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/9/97
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sarah Hall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		ADDRESS	
18. I I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 8 mos.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/27 1964 to 6/30 1969 that (H) (we) last saw the deceased alive on 6/30 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (T) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John H. Stobo		23B. DATE SIGNED 6/30/69	
23C. PHYSICIAN'S NAME (Type) John H. Stobo, M.D.		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-3-69	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.	24D. LOCATION (City, town, or county) (State) Balto Md
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969	25B. NAME OF REGISTRAR R. B. Sanders	25C. FUNERAL DIRECTOR Raymond Sanders	
25D. ADDRESS 217 E. Preston St			



H-236

69

6965

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6965

BIRTH NO.

1. NAME OF DECEASED (Type or Print) QUEENIE HESTER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1412 Aisquith St.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1969 2:04 a.m.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909	
9. DATE OF BIRTH 7-10-98		10. AGE (In years lost birthday) 71	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Motten		14. MOTHER'S MAIDEN NAME Hester Motten	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
23A. DATE OF OPERATION		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
24C. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		24D. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
24E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24F. HOW DID INJURY OCCUR?	
25. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Werner H. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
26A. BURIAL CREMATION, REMOVAL (Specify) Burial		26B. DATE 7-9-69	
26C. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery		26D. LOCATION (City, town, or county) (State) Stafford Co. Virginia	
26E. DATE REC'D BY HEALTH DEPT. JUL 10 1969		26F. NAME OF REGISTRAR Robert E. Fahey, M.D.	
26G. FUNERAL DIRECTOR Rayner Sanders		26H. ADDRESS 217 E. Preston St.	

ACADEMIC RECORD

Name		Grade		Date	
John Doe		10		1950	
Jane Smith		10		1950	
Robert Johnson		10		1950	
Mary White		10		1950	
William Brown		10		1950	
Elizabeth Black		10		1950	
James Green		10		1950	
Margaret Hill		10		1950	
Richard King		10		1950	
Susan Lee		10		1950	
Thomas Miller		10		1950	
Patricia Wilson		10		1950	
Daniel Taylor		10		1950	
Barbara Young		10		1950	
Christopher Hall		10		1950	
Jennifer Adams		10		1950	
Matthew Baker		10		1950	
Ashley Clark		10		1950	
Nathan Evans		10		1950	
Hannah Foster		10		1950	
Ethan Gibson		10		1950	
Olivia Harris		10		1950	
Jacob Kelly		10		1950	
Sophia Lewis		10		1950	
Benjamin Moore		10		1950	
Isabella Nelson		10		1950	
Lucas Parker		10		1950	
Ava Reed		10		1950	
Caleb Scott		10		1950	
Mia Turner		10		1950	
Elijah Vance		10		1950	
Charlotte Wells		10		1950	
Liam White		10		1950	
Amelia Young		10		1950	
Noah Adams		10		1950	
Evelyn Baker		10		1950	
Carter Clark		10		1950	
Samantha Evans		10		1950	
Wyatt Foster		10		1950	
Madeline Gibson		10		1950	
Grayson Harris		10		1950	
Lillian Kelly		10		1950	
Oscar Lewis		10		1950	
Cecilia Moore		10		1950	
Isaac Nelson		10		1950	
Vivian Parker		10		1950	
Caleb Reed		10		1950	
Frances Scott		10		1950	
Eugene Turner		10		1950	
Loretta Vance		10		1950	
Clyde Wells		10		1950	
Gladys White		10		1950	
Harold Young		10		1950	
Dorothy Adams		10		1950	
Ernest Baker		10		1950	
Mildred Clark		10		1950	
Clarence Evans		10		1950	
Eugenia Foster		10		1950	
Clifford Gibson		10		1950	
Lela Harris		10		1950	
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Leta Wells		10		1950	
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Clayton Parker					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6966	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>D-255</u> 69 6966 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>KATIE Beckman</u>			2. DATE AND HOUR OF DEATH <u>7/10/69</u> <u>16:25</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2719</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI Hospital of Baltimore inc</u>			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>5816 Jonquil Ave</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXXXX</u>	9. AGE (In years lost birthday) <u>78</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>DAVID STEIN</u>			14. MOTHER'S MAIDEN NAME <u>- HANNAH ELLA ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-4410B</u>	17. INFORMANT ADDRESS <u>MR. BERTRAM NEY, 3800 GLEN AVENUE #21215</u>		
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p><u>2509 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> 19 <u>69</u> to <u>7/10</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>7/10</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. S. Caplan MD</u>				23B. DATE SIGNED <u>7/10/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. S. CAPLAN</u>				23D. ADDRESS <u>SINAI Hosp BALTO</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-10-69</u>		24C. NAME of CEMETERY or CREMATORY <u>RIGA KURLANDER VEREIN</u>	
24D. LOCATION <u>ROSEDALE, MARYLAND</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	

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FUNERAL DIRECTOR: IMPORTANT

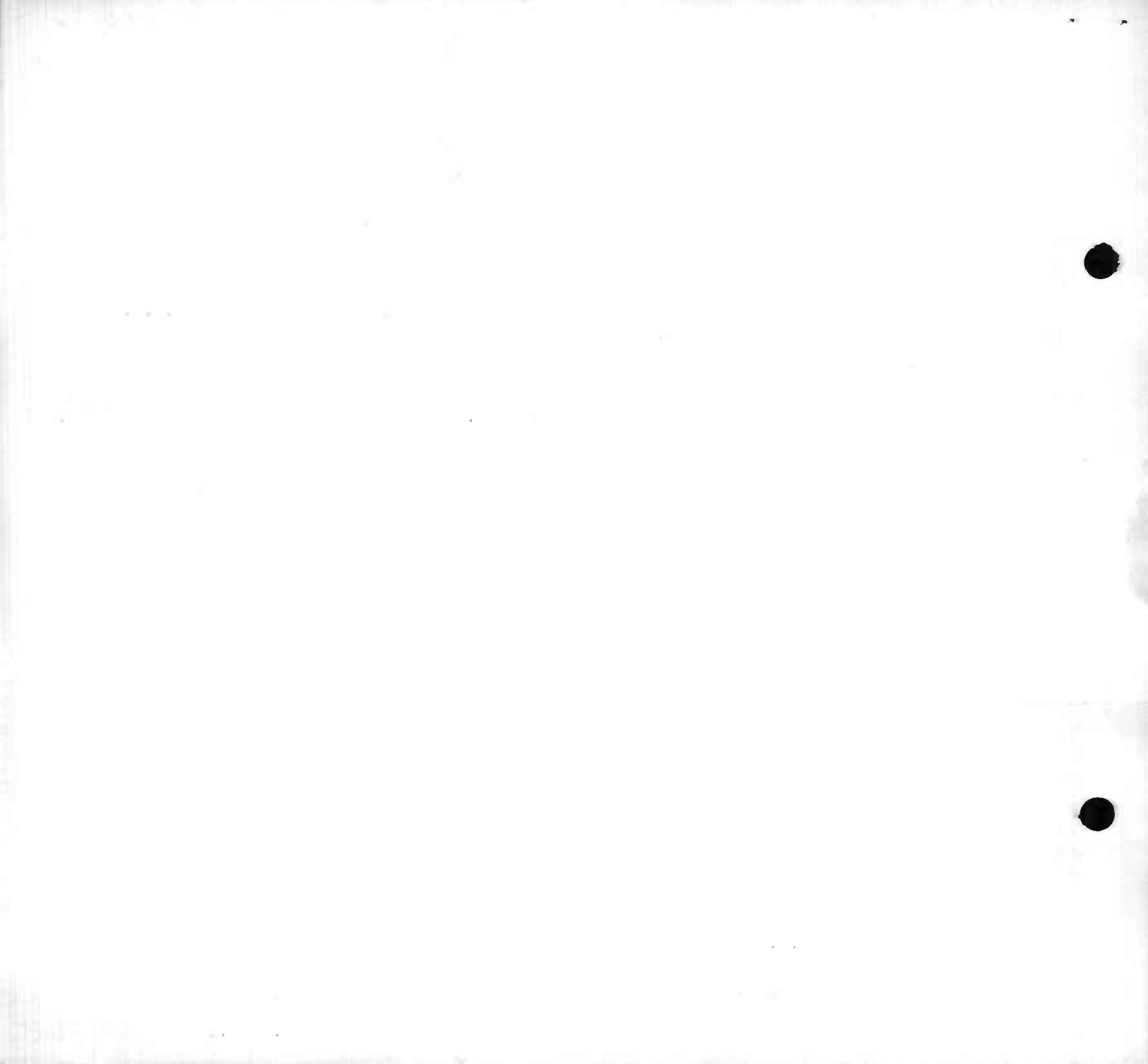
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6967	
<div style="display: flex; justify-content: space-between;"> D-255 69 6967 CERTIFICATE OF DEATH </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) LEE (LEON) (2) DICKMAN				2. DATE AND HOUR OF DEATH July 9, 1969 8:39 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION SINAI </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2740	
				C. CITY OR TOWN BALTIMORE	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
				E. STREET AND NUMBER 3306 GLEN AVE.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1910 8-16-XX	9. AGE (in years lost birthday) XX 49	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN Sun Life Ins. Co.
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MEYER DICKMAN			14. MOTHER'S MAIDEN NAME SARAH LEVIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY			16. SOCIAL SECURITY NO. 213-01-8452		
17. INFORMANT MR. CHARLES DICKMAN			ADDRESS 3306 GLEN AVENUE #15		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <p><small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small></p> </div> <div> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis, probable </div> <div> (B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction 7 yrs. Coronary Artery disease </div> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 to July 1969 that (I) (we) last saw the deceased alive on June 20, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William P. Benson, Jr. M.D.				23B. DATE SIGNED July 9, 1969	
23C. PHYSICIAN'S NAME (Type) WILLIAM P. BENSON, JR.				23D. ADDRESS 3502 N. CALVERT ST. BALT, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-69		24C. NAME of CEMETERY or CREMATORY BETH JACOB ANSHE VESHEAR	
24D. LOCATION ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

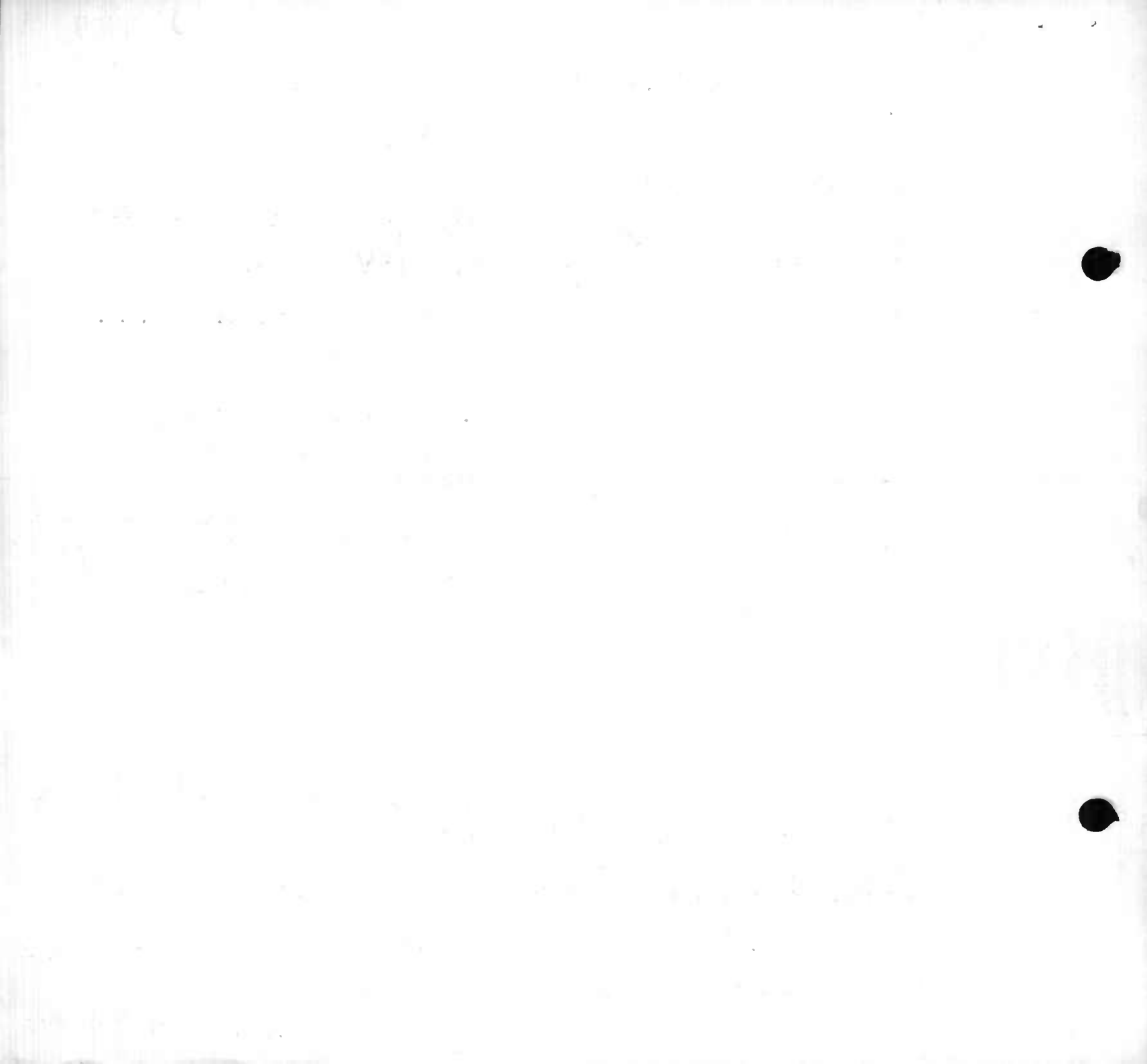
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6968	
0-155 69 6968 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		CLARA OPPENHEIMER		2. DATE AND HOUR OF DEATH 7/8/69 7:05 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD	
42 SINAI HOSPITAL OF BALTIMORE Inc				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5517 LYNVIEW AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/1886	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		BALTIMORE, MARYLAND	
13. FATHER'S NAME XXXXXX SAMUEL OPPENHEIMER				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME ISABELLE LOWENTHAL				17. INFORMANT MR. ALBERT OPPENHEIMER, 5517 LYNVIEW AVE. #15	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-46-6798		ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Cardiorespiratory failure				5 min	
(B) Chronic Respiratory failure				10 yrs	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 7-6 1969 to 7-8 1969 that (I) (we) last saw the deceased alive on 7-8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D.D. GAYNOR				23B. DATE SIGNED 7/8/69	
23C. PHYSICIAN'S NAME (Type) D.D. GAYNOR				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-69		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. JUL 10 1969		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		24H. ADDRESS		24I. DATE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

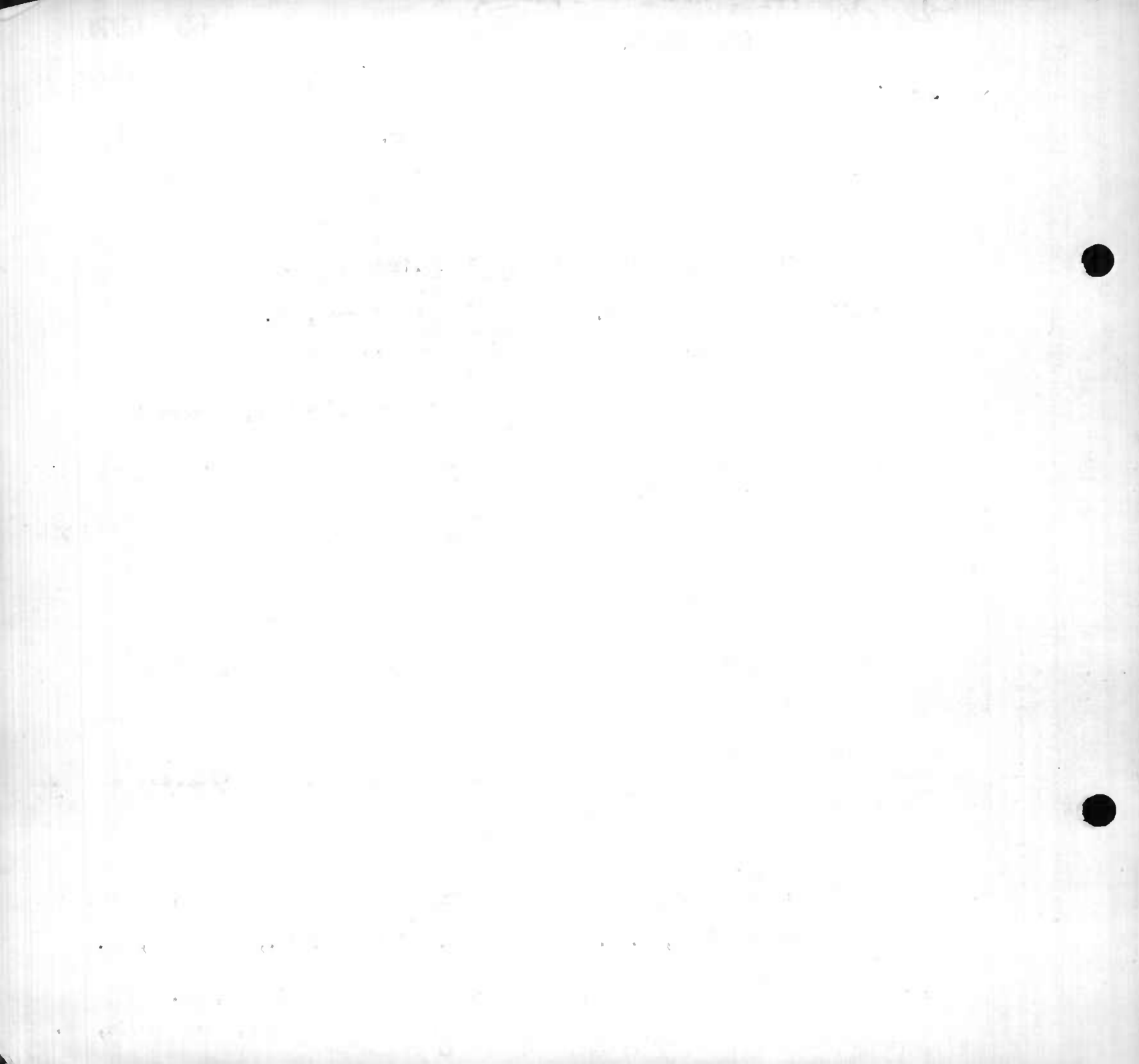
F-500 69 6969		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 69 6969	
1. NAME OF DECEASED (Type or Print) MELVIN L. FINE				2. DATE AND HOUR OF DEATH 7/7/69 8:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTA. CO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 12 SWAN HILL DRIVE #8			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/04	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY			10B. KIND OF BUSINESS OR INDUSTRY AT LAW		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MORRIS FINE				14. MOTHER'S MAIDEN NAME BERTHA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. BETTY FINE, 12 SWANHILL DRIVE #21208		
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO-RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYOCARDIAL INFARCTION ARTERIOCL. CV DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-30-69 7/2/69			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 6/20/69 to 7/1/69 that (1) (we) last saw the deceased alive on 7/7/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Peter A. Papraskuseur, M.D.				23B. DATE SIGNED 7/7/69		23C. PHYSICIAN'S NAME (Type) PETER A. PAPERASKUSEUR	
23D. ADDRESS SINAI HOSPITAL OF BALTIMORE				23E. DEGREE DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-9-69		24C. NAME of CEMETERY or CREMATORY BETH JACOB		24D. LOCATION (City, town, or county) (State) FINKSBURG, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Robert E. Jaber, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		25D. ADDRESS 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

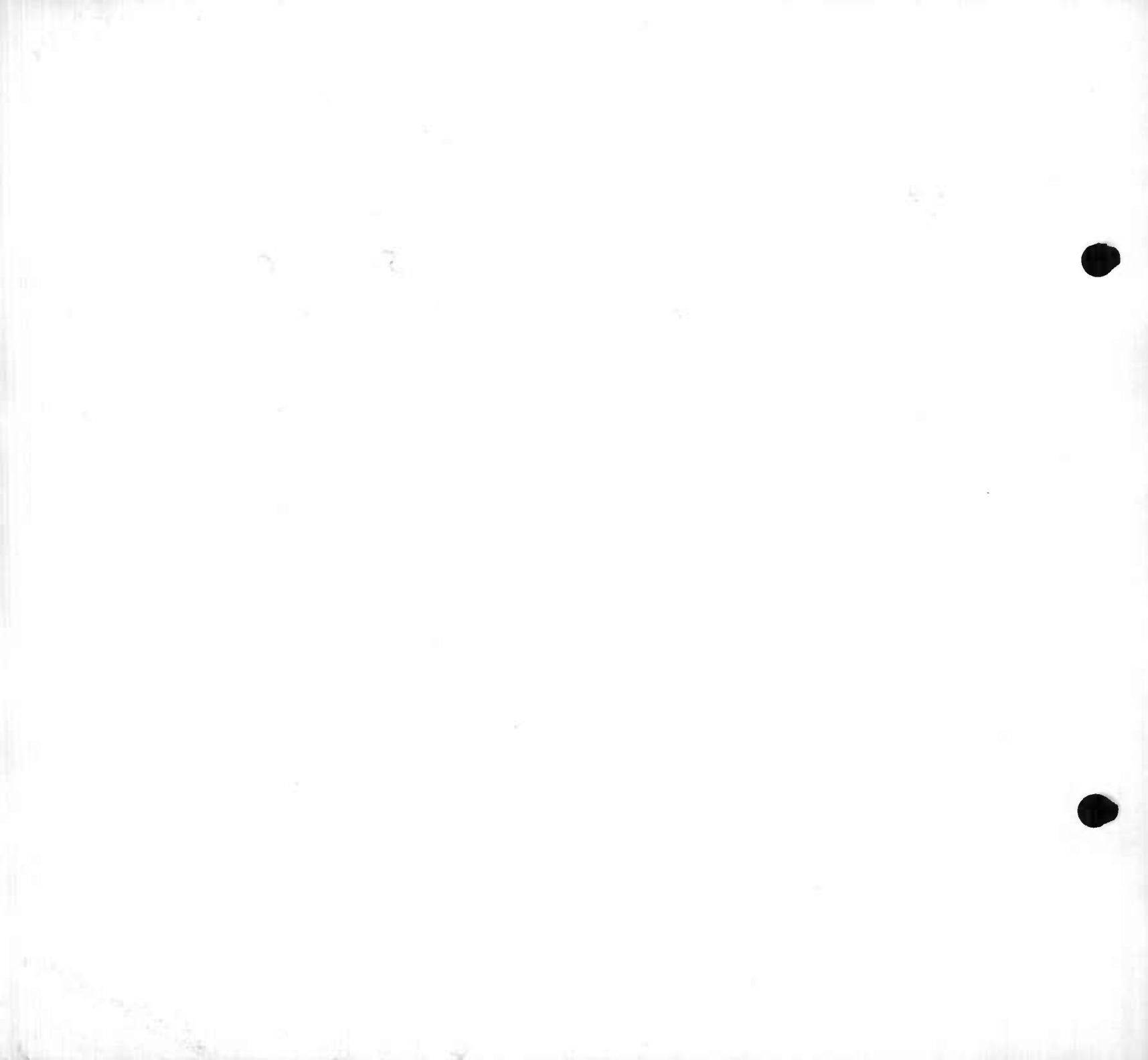
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69, 6970	
BIRTH NO.		69, 6970		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Albert Edward Hoerl			2. DATE AND HOUR OF DEATH 8 July 1969 440 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2551		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House in the Pines Nursing Home 90			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3307 Benson Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Nov. 1899	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10B. KIND OF BUSINESS OR INDUSTRY Ret.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Hoerl			14. MOTHER'S MAIDEN NAME Elizabeth Bowen		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT John Hoerl, Brother, same as 4		
18. 1410 I CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bo of blood to tongue several hrs Stroke (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 12 1969 to July 8 1969 , that (I) (we) last saw the deceased alive on July 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester Kolman M.D.			23B. DATE SIGNED 10 July 1969		
23C. PHYSICIAN'S NAME (Type) Lester Kolman, M. D.			23D. ADDRESS 6821 Reistertown Rd., Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11 July 69	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										REG. NO. 69 6971	
BIRTH NO. M-220		1. NAME OF DECEASED (Type or Print) Mogowski Anthony								2. DATE AND HOUR OF DEATH 7/9/69 8:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 201 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 203 S. Washington St.					
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/98		9. AGE (In years, last birthday) 70		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAYLOR				10B. KIND OF BUSINESS OR INDUSTRY TAYLORING				11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? LITHUANIA	
13. FATHER'S NAME George Mogowski						14. MOTHER'S MAIDEN NAME Katherine ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-32-0158		17. INFORMANT ADDRESS ALBERT MAGOWSKI 203 S. WASH. ST.					
18. 492X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: Cor. Pulmonale (B) DUE TO, OR AS A CONSEQUENCE OF: (C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6.30 1962 to 7.9 1962 that (I) (we) last saw the deceased alive on 7.9 1962 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
23A. SIGNATURE DARAB						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7.9.69.	
23C. PHYSICIAN'S NAME (Type) DARAB						23D. ADDRESS Bon Secours Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7/14/69		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY				24D. LOCATION (City, town, or county) (State) DUNDALK MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC.			
ADDRESS 401 S. CHESTER ST.											



P-425 69 6972 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 6972

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JUANITA MARY PLEASANT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 8, 1969 8:05 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL (BOA)		3. DATE PRONOUNCED DEAD Month Day Year July 8, 1969 8:05 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH NOV 8 1922		10. AGE (In years lost birthday) 46	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER		15. MOTHER'S MAIDEN NAME ANNIE BOWHES	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT MR. BB. PLEASANT BRO.		ADDRESS 7702 ANTIMONETTER RD. RICHMOND VA.	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	CAUSE OF DEATH Asphyxia due to food bolus in trachea	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7702 ANTIMONETTER RD. RICHMOND VA.
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
	(B) DUE TO, OR AS A CONSEQUENCE OF:	
	(C) DUE TO, OR AS A CONSEQUENCE OF:	

20A. DATE OF OPERATION 7/11/69	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute ethylism	21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2102 E. Monument Street
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) July 8, 1969 P.M.	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Subj. asphyxiated on food bolus

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: **Ronald N. Kornblum, M.D.** CHIEF MEDICAL EXAMINER ☐
 EXAMINER'S NAME (Type) DATE SIGNED
6/9/69

ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE JULY 12 1969	24C. NAME OF CEMETERY or CREMATORY WINN'S BAP. CH. CEM.	24D. LOCATION (City, town, or county) (State) GLEN ALLEN VA.
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1969	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Brewd Clayton 2nd	ADDRESS 2nd

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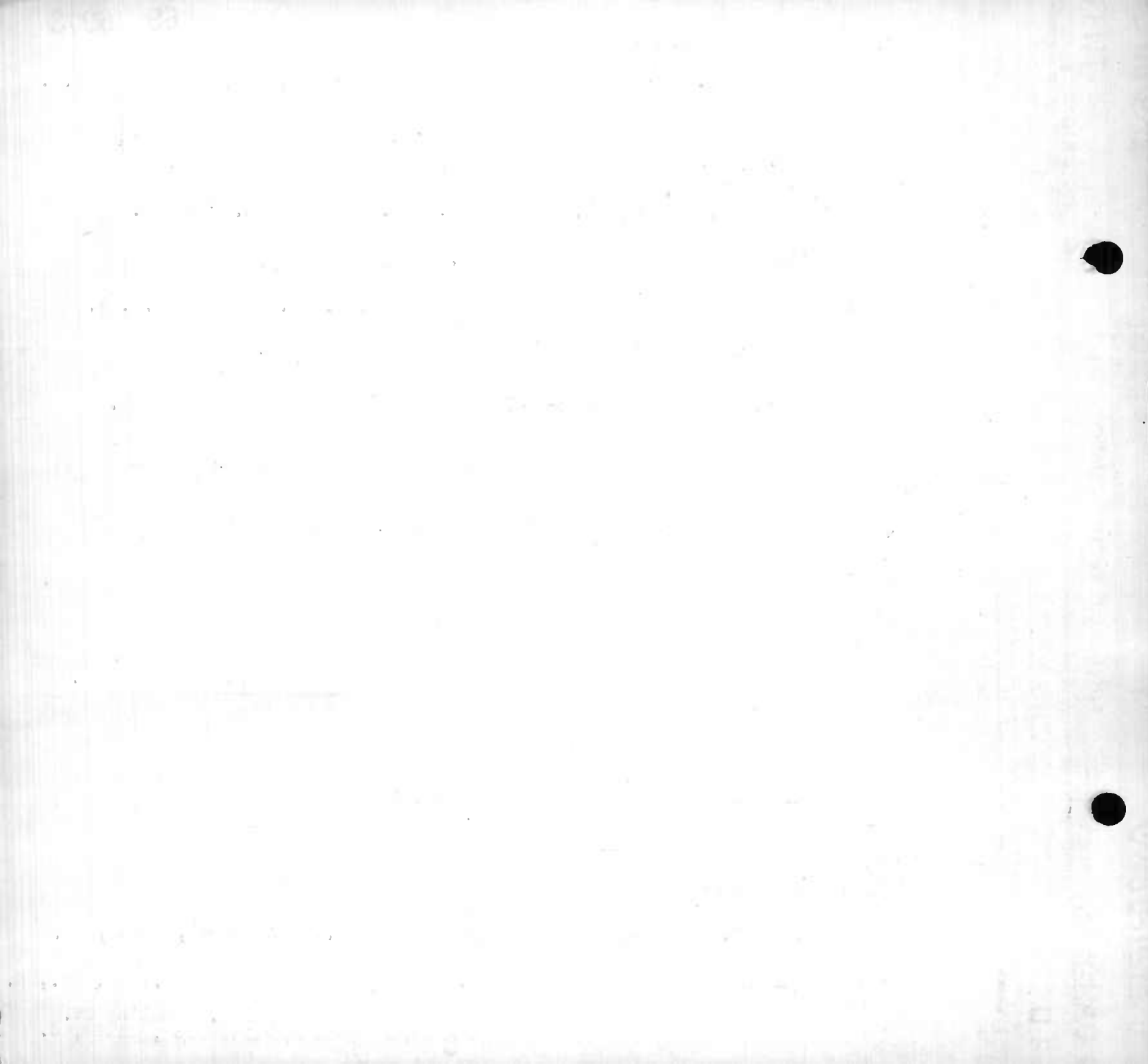
00 0000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

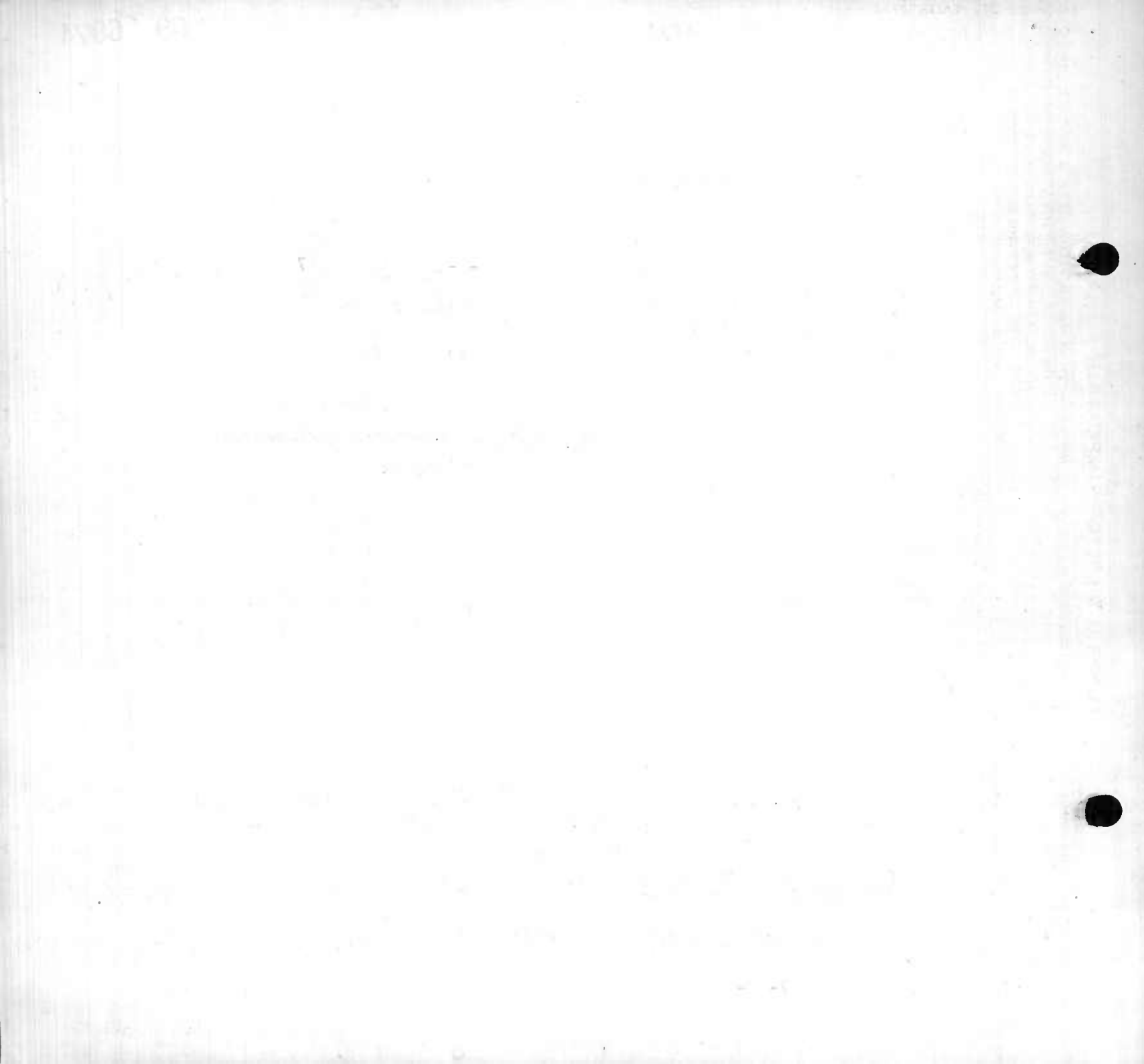
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69, 6973	
<div style="display: flex; justify-content: space-between;"> 5-422-69 6973 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY T. SLEZAK		July 7, 1969 12:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Belaire-House in the Pines 5837 Belair Rd. Baltimore, 21206, Md.		
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Retired		House Work		Dec. 6, 1899	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
Maybury, W. Va.		U.S.A.		69	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Orlick			Gabrina Hruz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-12-3087		Margaret Slezak	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Multiple Cerebral Thrombosis		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		—	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF:		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) Dystrophic myelitis Edema			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from <u>6/14/69</u> to <u>7/7/69</u> , that (I) (we) last saw the deceased alive on <u>7/6/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Albert B. Bradley					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ALBERT B. BRADLEY				4900 Belair Rd., Baltimore, 21206, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-10-69		Sacred Heart Cemetery	
24D. LOCATION		24E. CITY, TOWN, or COUNTY		24F. STATE	
7401 German Hill Rd.,		Ba. Co.,		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 10 1969		Robert E. Fisher, Jr.		901 S. Conkling St. Baltimore, 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6974	
<div style="display: flex; justify-content: space-between;"> P-242 69 6974 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Frances Pakulski			2. DATE AND HOUR OF DEATH July 8 1969 5:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 2605		
FULL NAME OF HOSPITAL OR INSTITUTION 00 362 Drew Street Baltimore			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 362 Drew Street					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1902		9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? 2605
13. FATHER'S NAME Peter Novak			14. MOTHER'S MAIDEN NAME Tena Hudzik		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Adam Pakulski 362 Drew Street		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.3 I Hypertensive cardiac - Vascular disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1966 to 7/8 1969 , that (I) (was) last saw the deceased alive on 7/7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.					
23A. SIGNATURE Joseph R. Liberto, M.D.				23B. DATE SIGNED 7/9/69	
23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO M.D.		23D. ADDRESS 3508 BANK ST, Baltimore, MD 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-II-1969	24C. NAME OF CEMETERY or CREMATORY St Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REG'D BY HEALTH DEPT. JUL 10 1969		25B. NAME OF REGISTRAR Joseph E. Liberto, M.D.		25C. FUNERAL DIRECTOR ADDRESS WALTER DABROWSKI 1005 DUNDALK AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6975	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) STOLBA, JOSEPHINE M.		2. DATE AND HOUR OF DEATH 7/8/69. 11:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL 301 SHANOVER ST. BALTO, MD, 21230.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 2605 C. CITY OR TQWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 437 S. DREW ST. #21224.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1909	9. AGE (in years lost birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH LANG (Dec.)			14. MOTHER'S MAIDEN NAME ANNA FISCHER (Dec.)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-44-0317		17. INFORMANT FRANK HANV. STOLBA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) CIRRHOSIS OF LIVER DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-19 19 69 to 7/8 19 69 that (I) (we) last saw the deceased alive on 7-8 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry Alan Blum MD				23B. DATE SIGNED 7-8-69	
23C. PHYSICIAN'S NAME (Type) BARRY ALAN BLUM MD		23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-11-69		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	
24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD, BA.CO., MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969			
25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR 6224 EASTERN AVE. BALTO, 21224, MD.			

C-155 69 6976 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 6976

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM CHAPMAN		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> July 9, 1969		Month Day Year		Hour 4:35 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL		3. DATE PRONOUNCED DEAD July 9, 1969		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY 1802			
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 11/20/91		10. AGE (In years last birthday) 77		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Chapman	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clark (Post Office) Balto. City Post Office		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Alice ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		17. SOCIAL SECURITY NO. 214-38-8825	
18. INFORMANT Ethel Chapman		ADDRESS 308 N. Carrollton Ave		19. CAUSE OF DEATH Acute Peritonitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Perforation of Duodenal Ulcer		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic cardiovascular disease		20A. DATE OF OPERATION 7/14/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/9/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/69		24C. NAME OF CEMETERY or CREMATORY Balto. National		24D. LOCATION (City, town, or county) (State) Balto. Ind.			
25A. DATE REC'D BY HEALTH DEPT. 11/11/1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Wm. L. Chatman, Jr.		ADDRESS 1701 Mt. Calhoun St. Baltimore			

W.C.T. 211-21-212 F.W.C. Chapman - 211-21-212
Crick (Post office) 211-21-212 F.W.C. Chapman - 211-21-212
J.W.C. 211-21-212 F.W.C. Chapman - 211-21-212

James W. McLaughlin

Wm. L. Johnston, Jr. (1871-1944)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-230 69 6977 CERTIFICATE OF DEATH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6977	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Reginald Buchta</u>			
2. DATE AND HOUR OF DEATH <u>July 8, 1969 9:20 P.M.</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2653</u>				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>			
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <u>5062 E. Federal St.</u>			
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-93</u> 9. AGE (in years last birthday) <u>76</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>United States (Maryland)</u>				12. CITIZEN OF WHAT COUNTRY <u>—</u>			
13. FATHER'S NAME <u>Frederick Buchta</u>				14. MOTHER'S MAIDEN NAME <u>Regina ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-07-9989</u>		17. INFORMANT ADDRESS <u>Hospital Records</u>	
18. <u>519.2.1</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Septic Shock</u>				<u>< 48 hours</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u>				<u>< 48 hours</u>			
(C) <u>Chronic Obstructive Lung Disease</u>				<u>Years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>—</u>							
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1969</u> to <u>July 8, 1969</u> that (I) (we) last saw the deceased alive on <u>July 8, 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William L. Boddie, M.D.</u>				23B. DATE SIGNED <u>7-8-69</u>		23C. PHYSICIAN'S NAME (Type) <u>William L. Boddie</u>	
23D. ADDRESS <u>Maryland General Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>7-12-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1969</u>		25B. NAME OF REGISTRAR <u>John G. Miller, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John G. Miller Inc-6415 Belair Rd.-21206</u>			



H-520

69 6978

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6978

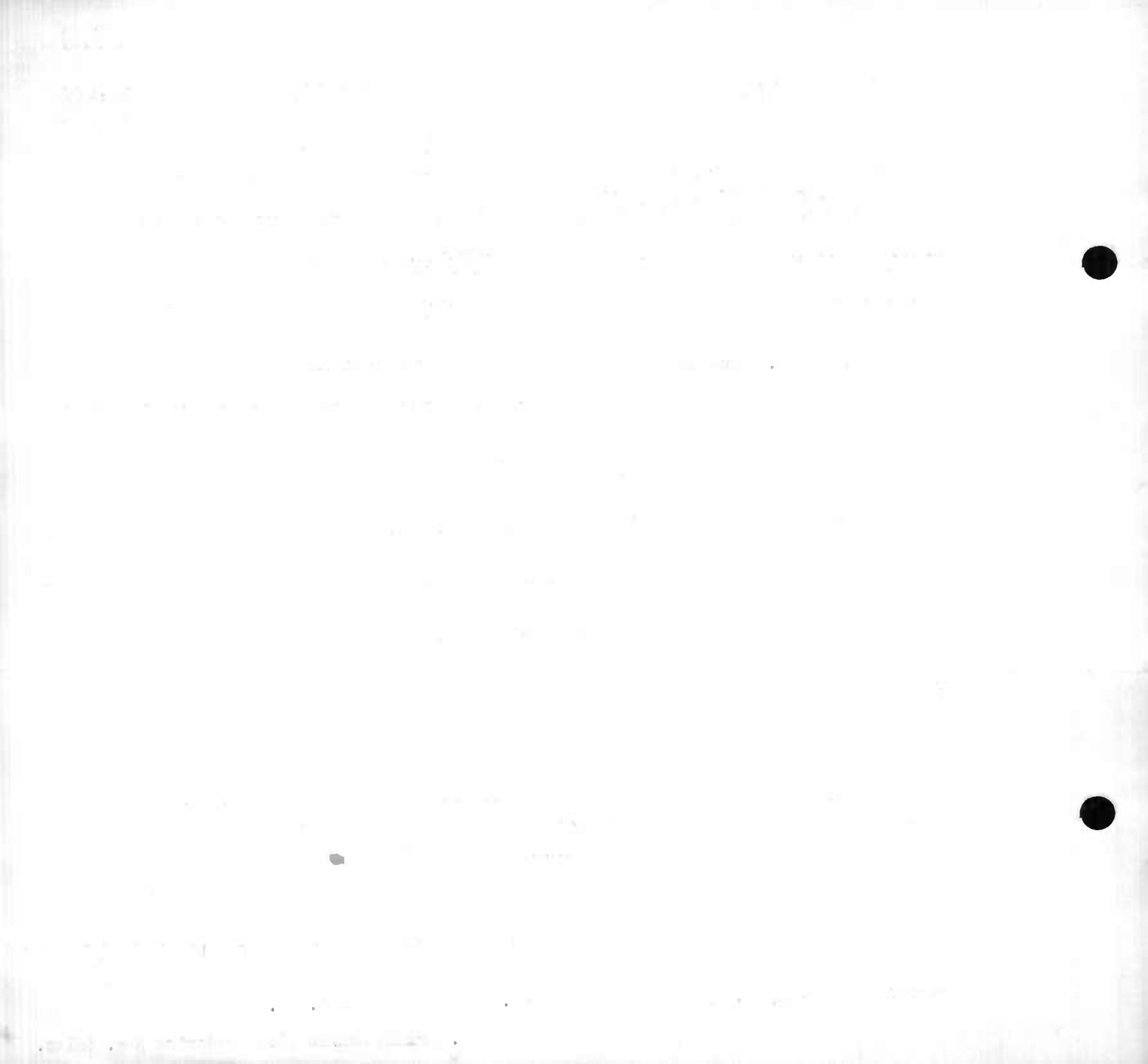
BIRTH NO. <u>LINDSAY</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> July 7, 1969 M.	
1. NAME OF DECEASED (Type or Print) <u>WILLIAM HAINES</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour July 7, 1969 11:25 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital (DOA)</u>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2717</u>	
6. SEX <u>Male</u>	7. RACE <u>White</u>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <u>22 FEB 16</u>	10. AGE (In years lost birthday) <u>53</u>	E. STREET AND NUMBER <u>3049 Spaulding Avenue Balto. Md. 21215</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from U.S. ARMY</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
15. MOTHER'S MAIDEN NAME <u>Mary May Stewart</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES <u>WW II</u>	
17. SOCIAL SECURITY NO. <u>187 01 0873</u>		18. INFORMANT <u>Mrs. Maria T. Haines</u> ADDRESS <u>Baltimore, Maryland 21215</u> <u>3049 Spaulding Avenue</u>	
19. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <u>Yes</u>		22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10 JUL 69</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>J. E. Lowell Lemmon</u>		ADDRESS <u>4611 Park Heights Ave.</u>	

ACADEMIC RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

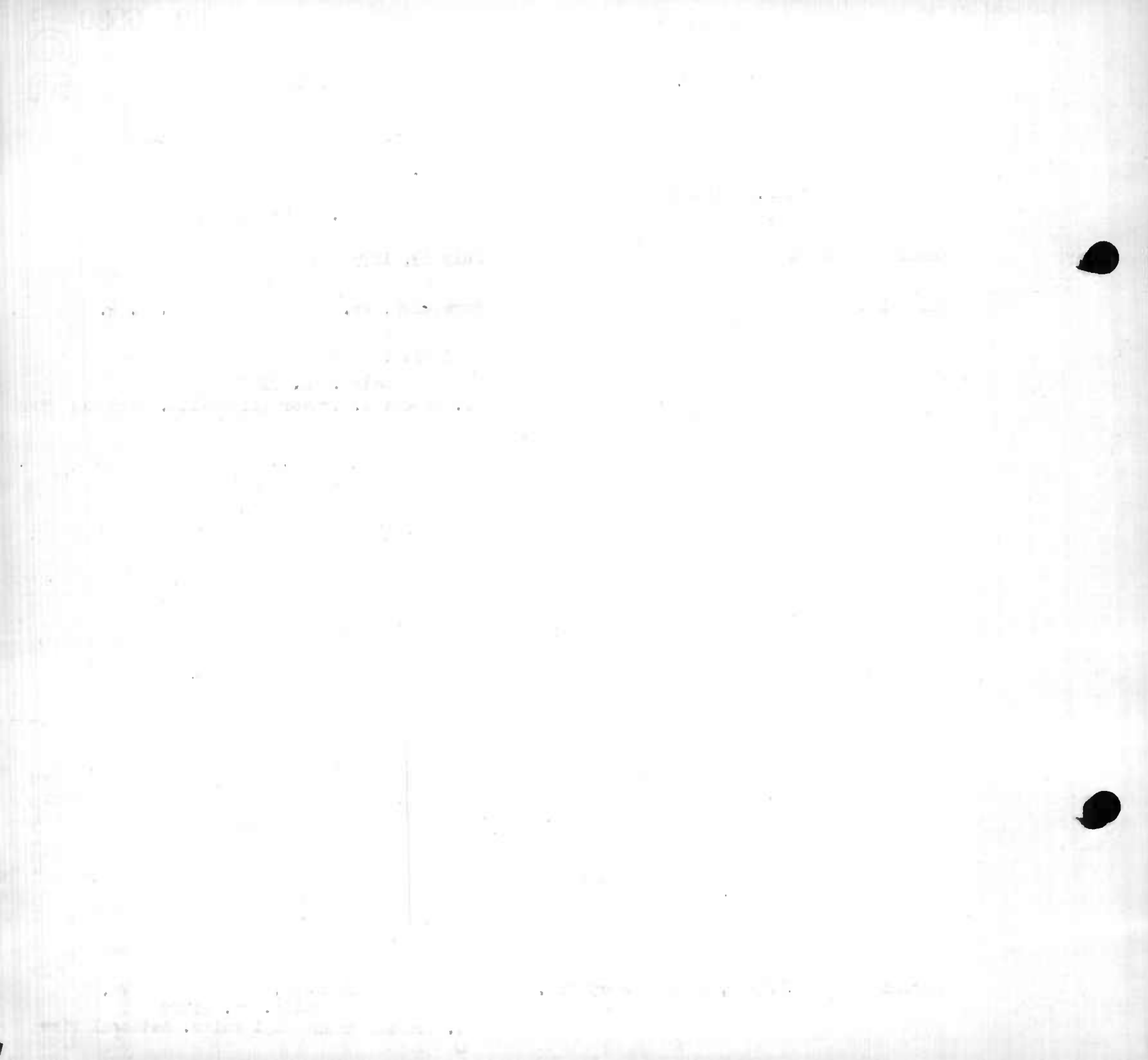
P-400		69 6979		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6979	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) POHLE JULIA MARY				07/06/69 10:40AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229				A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 40 S MONASTERY AVENUE 21229			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/1/1890	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 79		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME James L. Connelly				14. MOTHER'S MAIDEN NAME Sarah Bradburn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 212 10 4539		17. INFORMANT ADDRESS ST AGNES HOSP CATON & WILKENS AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD		(C) DUE TO, OR AS A CONSEQUENCE OF: ASCVD	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 06/30/69 19 to 07/06/69 19 that (X) (we) last saw the deceased alive on 07/06/69 19 and that in (Xy) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alejandro Lopez						23B. DATE SIGNED 07 06 69	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO LOPEZ				23D. ADDRESS ST AGNES HOSP CATON & WILKENS AVE 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 9, 1969		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave. Balto.	



FUNERAL DIRECTOR: IMPORTANT

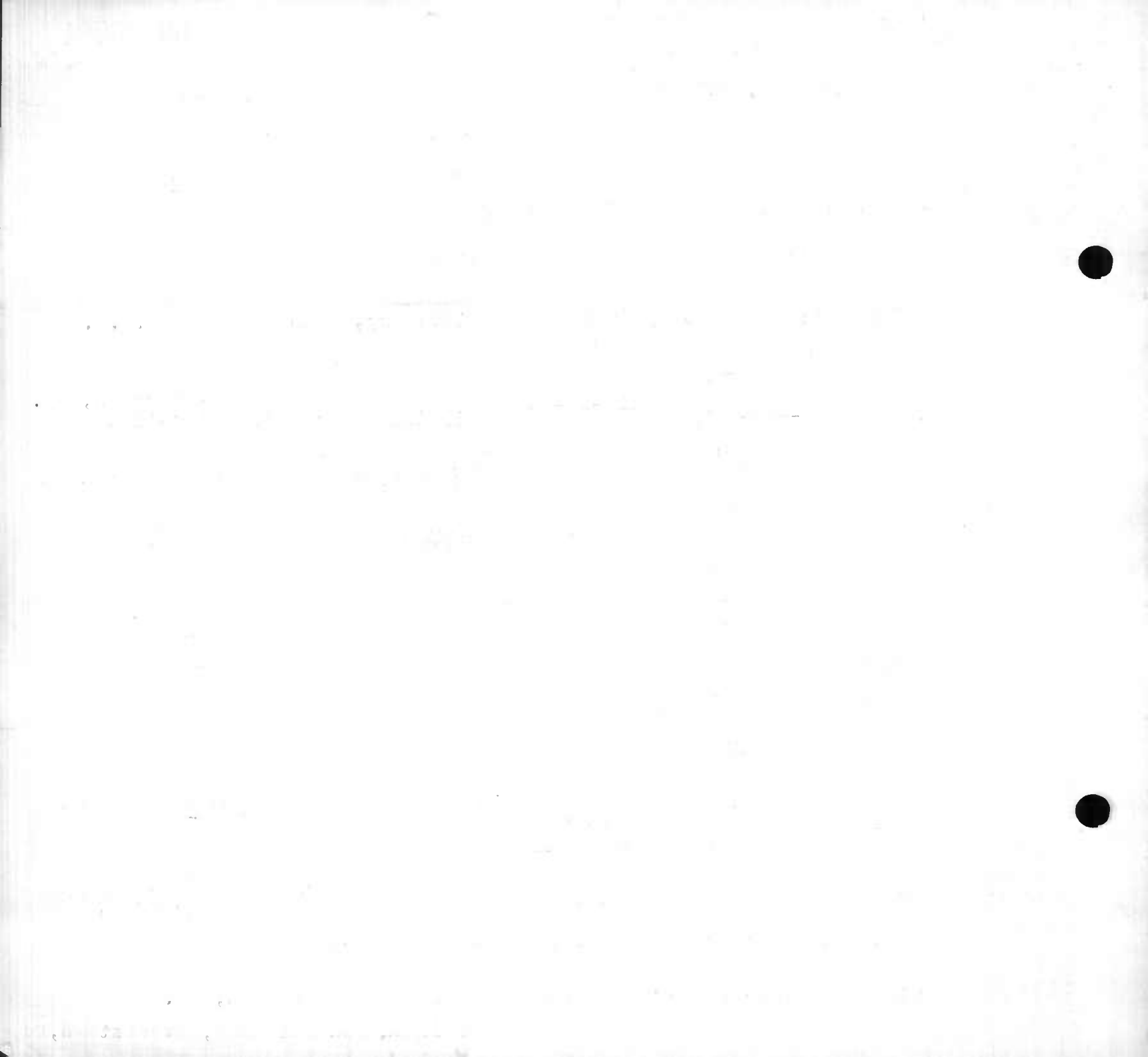
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69, 6980	
G-616		69 6980		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Lillian E. Grover			2. DATE AND HOUR OF DEATH July 5, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5113 Balto. National Pike			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5113 Balto. National Pike		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1895	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Burkeleigh, Va.	
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME Minnie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Balto. Md. 21229 Mr. Robert W. Grover 5113 Balto. National Pike	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MASSIVE MYOCARDIAL INFARCTION CORONARY ARTERY DISEASE ARTERIO SCLEROSIS, GENERALIZED			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Less than 24 hrs 7 YEARS At least 16 yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Obesity, MODERATE			16 years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 15, 1953 to July 5, 1969 , that (I) (we) last saw the deceased alive on February 17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin N. Borden MD				23B. DATE SIGNED July 6, 1969	
23C. PHYSICIAN'S NAME (Type) Robert E. Taylor, M.D.				23D. ADDRESS 5000 BALTIMORE NATIONAL PIKE BALTIMORE, MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 9, 1969		24C. NAME of CEMETERY or CREMATORY Maury Cem.	
24D. LOCATION (City, town, or county) (State) Richmond, Va.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Balto. Md. 21229 G. Truman Schwab 5151 Balto. National Pike			



29 02 58
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	
C-325 69 6981				REG. NO. 69 6981	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHATKIN, Robert		7/9/69 2:20 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital			A. STATE B. COUNTY Maryland Washington 7103		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Hagerstown YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 401 Summit Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/9/02	67	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Pharmacist		Retired Drug Store		Pittsburg, Penna	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Chatkin			Stella Chatkin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT
no			218-30-9689		William C. Chatkin, 901 Rolling Rd
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			MYOCARDIAL INFARCTION 12 hours		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ATHEROSCLEROTIC VASCULAR DISEASE + Pulmonary Emboli		
			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				NO	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 1 1969 to July 9 1969 that (I) (we) last saw the deceased alive on July 9 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dale N. Schumacher M.D. DEGREE				July 9, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dale N. Schumacher, M.D. DEGREE				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/10/69		B'nai Abraham Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 11 1969		Robert E. Goffman		Goffman Funeral Home, Hagerstown, Md	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-361		69 6982		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 6982	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Anna K. PETROVICH				2. DATE AND HOUR OF DEATH 7/8/69 6 ²⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY Baltimore				C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL of Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 1104 Wood Heights Ave #11	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 28 1892		9. AGE (In years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ranshaw (Penna)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles BAHONIS				14. MOTHER'S MAIDEN NAME Cristina GVIADUNIAS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Agnes Glowa (daughter)			
						ADDRESS 8915 Waltham-Wood Rd, Balto #34			
18. 250.9 I				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident				3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertensive Arteriosclerotic Cardio. Dis.				Several years	
				(C) Diabetes				Several years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/3 1969 to 7/6 1969 that (I) (we) last saw the deceased alive on 7/6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature] M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/69			
23C. PHYSICIAN'S NAME (Type) AGUSTIN COLLADO				23D. ADDRESS Sinai Hospital of Balto.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE July 9, 1969		24C. NAME of CEMETERY or CREMATORY GARDENS of FAITH		24D. LOCATION TRUMP MILL RD. BALTI. CO., MD			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR BURGESS FUNERAL HOME		ADDRESS 3631 FALLS R.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6983

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATIE IDELL LUDWICK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1643 N. Calvert Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 7, 1969 3:45 A. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct. 16, 1917		10. AGE (In years last birthday) 51 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF USA	
13. FATHER'S NAME J.C. LINEBERRY		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	
15. MOTHER'S MAIDEN NAME IDA. RAMSEY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 238-30-5438		18. INFORMANT JOHN ROBERT LUDWICK	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7/10/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: July 7, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/10/69	
24C. NAME OF CEMETERY or CREMATORY BAPTIST Church Cem.		24D. LOCATION (City, town, or county) (State) DUNNS MT. ROWAN Co. N.C.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR BURGEE FUNERAL HOME		25D. ADDRESS 3631 FALLS Rd	

ACADEMIC LEONARD

1905-1906

1906-1907

1907-1908

1908-1909

1909-1910

1910-1911

1911-1912

1912-1913

1913-1914

1914-1915

1915-1916

1916-1917

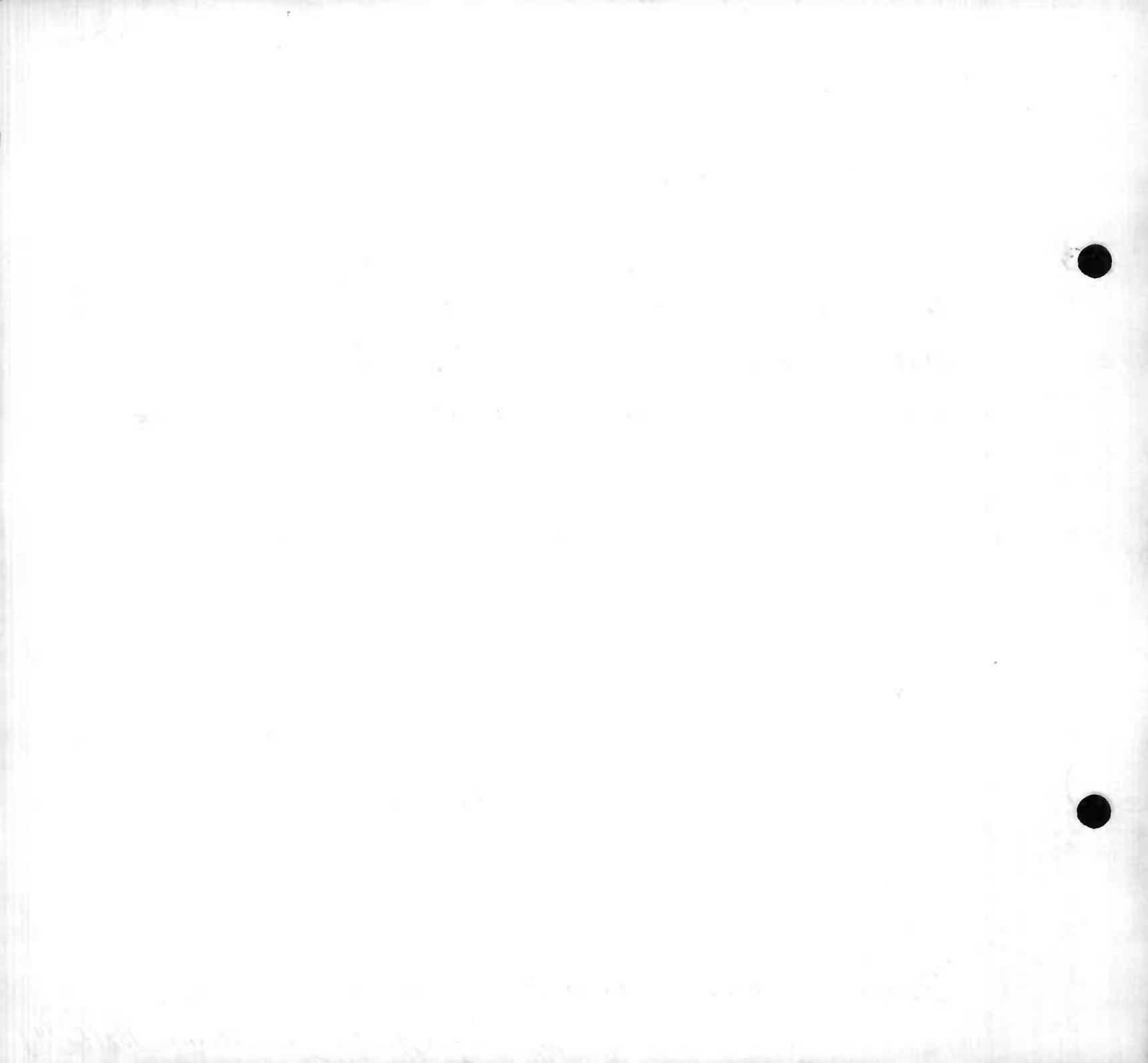
1917-1918

1918-1919

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

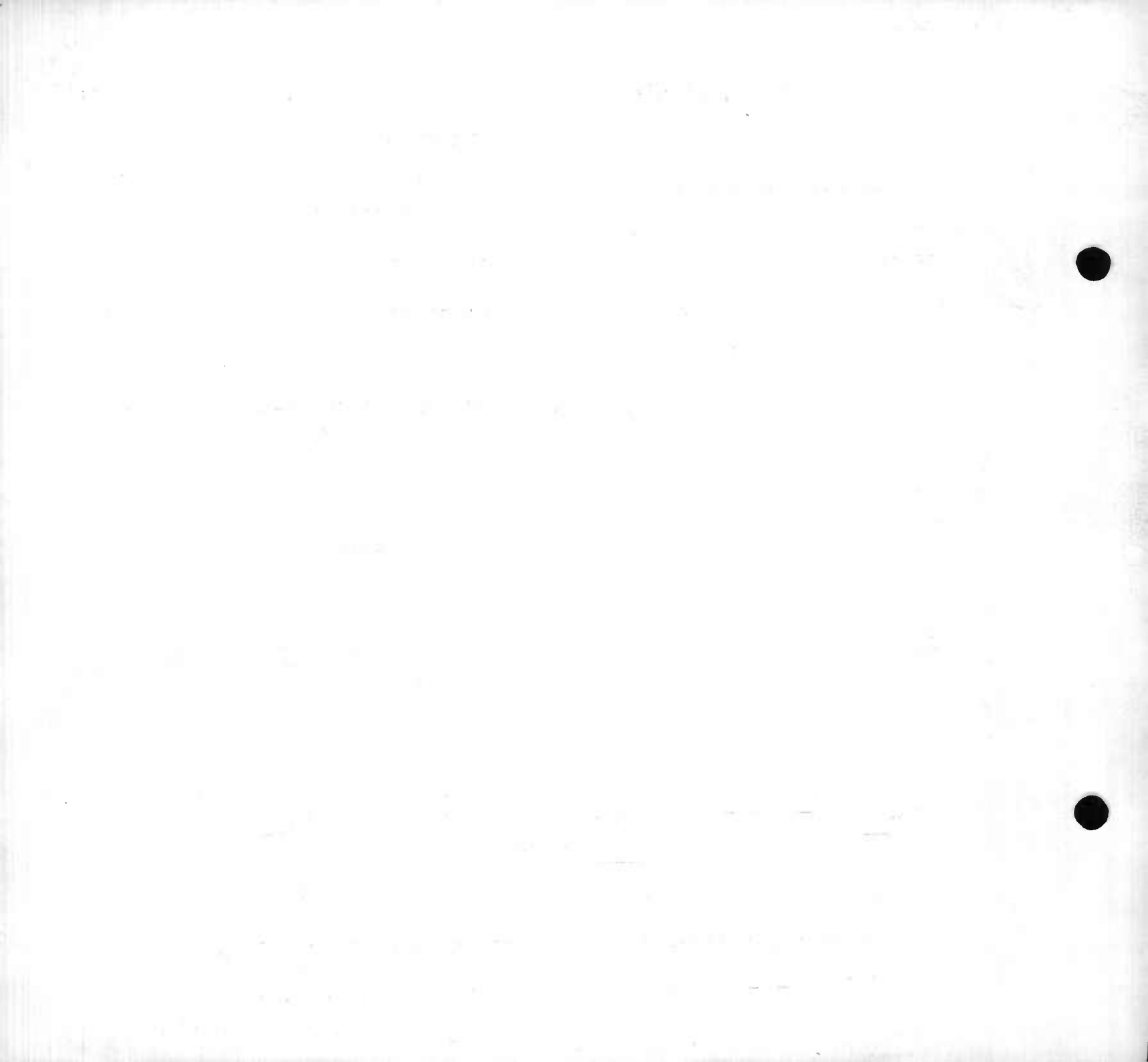
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6984	
L-000 69 6984 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARGAREL N LEE			
2. DATE AND HOUR OF DEATH		July 9, 1969 6:15 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY 1348	
42 SINAI HOSPITAL OF BALTIMORE INC.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH October 12, 1882	
Housewife		-		9. AGE (in years last birthday) 86	
13. FATHER'S NAME Malachi Lee		14. MOTHER'S MAIDEN NAME Alice Hardy		11. BIRTHPLACE (State or foreign country) Md	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218521188		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
17. INFORMANT		ADDRESS			
Martha F Schroth		Same			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		7 DAYS -			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CONGESTIVE HEART FAILURE			
ANTECEDENT CAUSES		(B) ARTERIOESCLEROTIC HEART DISEASE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 30 19 69 to July 9 19 69					
that (I) (we) last saw the deceased alive on July 9 19 69		and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
DUBEN DRUANSKI M.D.		July 9, 1969		DUBEN DRUANSKI M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-12-69		LORRAINE PARK Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 11 1969		Robert E. Fisher, M.D.		Burges Funeral Home Balto Md	
26A. ADDRESS		26B. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6985	
<div style="display: flex; justify-content: space-between;"> H-634 69 6985 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HARTEL, MINNIE LEE		JULY 9, 1969 8:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			A. STATE MARYLAND		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 907 DE SOTO ROAD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 06 01	9. AGE (in years last birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY Produce	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Thacker			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219 18 7611	17. INFORMANT ADDRESS ST AGNES RECORDS-CATON & WILKENS AVE		
18. 1959 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Malignant tumor of chest wall ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 23 19 69 to JULY 9 19 69 that (X) (we) lost saw the deceased alive on JULY 9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jesada Muangsombut				23B. DATE SIGNED 7-9-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JESADA MUANGSOMBUT		ST AGNES BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial	7-12-69	Meadowridge Mem Ph Cem		Elthridge, Howard Co Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert F. Taylor, M.D.		25C. FUNERAL DIRECTOR Thomas J. Kenney Inc 1600 Hollins St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) NANCY MARSHALL				2. DATE AND HOUR OF DEATH July 7, 1969		8:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY 2301	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS OR LOCATION 4940 Eastern Avenue Baltimore, Maryland 21224				E. STREET AND NUMBER 105 W. Henrietta Street 21230			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-25		9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Brown				14. MOTHER'S MAIDEN NAME Nancy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT BCH; Records 4940 Eastern Ave. Balto. Md.		ADDRESS 21224
18. 4-27-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Uremia				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremia		(B) DUE TO, OR AS A CONSEQUENCE OF: 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-4 19 69 to 7-7 19 69 , that (I) (we) last saw the deceased alive on 7-7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John R. Brechtel				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-7-69	
23C. PHYSICIAN'S NAME (Type) JOHN R. BRECHTEL				23D. ADDRESS Baltimore City Hospital 4940 Eastern Avenue 5944 E. PRATT ST. BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-69		24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cont		24D. LOCATION (City, town, & county) (State) Balti. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Edna D. Wilson		ADDRESS 1000 Bunting	

Garage West

Illinois

Dr. H. B. Smith

June 1, 1915

Dear Dr. H. B. Smith:

J-250 69 6987 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 6987

1. NAME OF DECEASED (Type or Print) RAYMOND A. JACKSON		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> July 9, 1969		3. DATE PRONOUNCED DEAD Month Day Year July 9, 1969	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2501 Lauretta Avenue		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1605			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct-24, 1918		10. AGE (In years lost birthday) 50		E. STREET AND NUMBER 2501 Lauretta Avenue	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Henry Jackson	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		14B. KIND OF BUSINESS OR INDUSTRY None		15. MOTHER'S MAIDEN NAME Chapman Roles	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO.		18. INFORMANT Brandy Foster	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) genetic Bronchopneumonia Carcinoma with Metastases		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/9/69					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-69		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REG'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Henry J. Wilcox	
				ADDRESS 1000 B. Smith Ave.	

1940

STATE OF TEXAS

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PAUL D. JENKINS

PLANT CONTINENT

VALLEY VIEW

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6988
BIRTH NO. K-500 69 6988 1. NAME OF DECEASED (Type or Print) Baby Boy "C" Kenney		2. DATE AND HOUR OF DEATH June 28, 1969 8:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. Gen. Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2768 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1026 Woodson Rd 21212		
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1969	9. AGE (in years last birthday) 1 4 21
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY —		
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Norman Darling Kenney-Jr.		14. MOTHER'S MAIDEN NAME Elizabeth Bowman Cowan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT mother
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 740X I		CAUSE OF DEATH Anencephaly (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 27 1969 to June 28 1969 that (I) (we) last saw the deceased alive on June 28 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Migilio G. Janer		23B. DATE SIGNED 6-28-69		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-1-69		24C. NAME OF CEMETERY OR CREMATORY
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Taber, Jr.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-530 69 6989				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6989			
1. NAME OF DECEASED (Type or Print) BEATRICE SMITH				2. DATE AND HOUR OF DEATH JULY 1, 1969 12⁰³ P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION LAKE DRIVE NURSING HOME 2401 EUTAW PLACE BALTIMORE, MD 21217				A. STATE MD.				B. COUNTY 1510			
5. SEX F				6. RACE NEGRO				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. DATE OF BIRTH 11/2/23				10. AGE (In years last birthday) 56			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME EMORY COOPER				14. MOTHER'S MAIDEN NAME LUCILLE CURTIS							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. UNKNOWN				17. INFORMANT Sanjark Young, RN			
18. CAUSE OF DEATH 975X I				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic anginous heart failure -				(B) DUE TO, OR AS A CONSEQUENCE OF: Rheumatic carditis			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
21. DATE OF OPERATION 0				22. CONDITION FOR WHICH OPERATION WAS PERFORMED				23. AUTOPSY? (Yes or No)			
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				25. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)				26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
27. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				29. HOW DID INJURY OCCUR?			
30. I certify that (I) (this hospital) attended the deceased from March 25, 1969 to July 1, 1969 , that (I) (we) last saw the deceased alive on June 24, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
31. SIGNATURE Dr. Arthur M.D.				32. DATE SIGNED 7/1/69							
33. PHYSICIAN'S NAME (Type) DIANE ELINOR F. ALBUERNE MD.				34. ADDRESS 5713 CANTONMENT PKY APT 6A BALD MD 21212							
35. BURIAL CREMATION, REMOVAL (Specify) 7-7-69				36. NAME OF CEMETERY or CREMATOR UNIVERSITY MEDICAL SCHOOL				37. ADDRESS MORTUARY SERVICE - BCHO			
38. DATE REC'D BY HEALTH DEPT. JUL 11 1969				39. NAME OF REGISTRAR Robert E. Taylor, M.D.				40. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO			

The following is a list of the names of the persons who have been appointed to the various positions in the office of the Secretary of the State of New York.

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The following is a list of the names of the persons who have been appointed to the various positions in the office of the Secretary of the State of New York.

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69

6990

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH COLEMAN

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

June 29, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 29, 1969

12:20 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

00-00

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)

603

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty metamorphosis of liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

7-7-69

24C. NAME OF CEMETERY OR CREMATOR

24D. LOCATION (City, town or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 11 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

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MAIL ROOM

RECEIVED

10-1-7

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LEONARD L. ZUNTHRUN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 24, 1969 10:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3401 Harmony Ct.		3. DATE PRONOUNCED DEAD Month Day Year May 24, 1969 10:00 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2609	
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 77 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 3401 Harmony Ct.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Nodular hyperplasia of prostate		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/24/69					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-7-69		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS	

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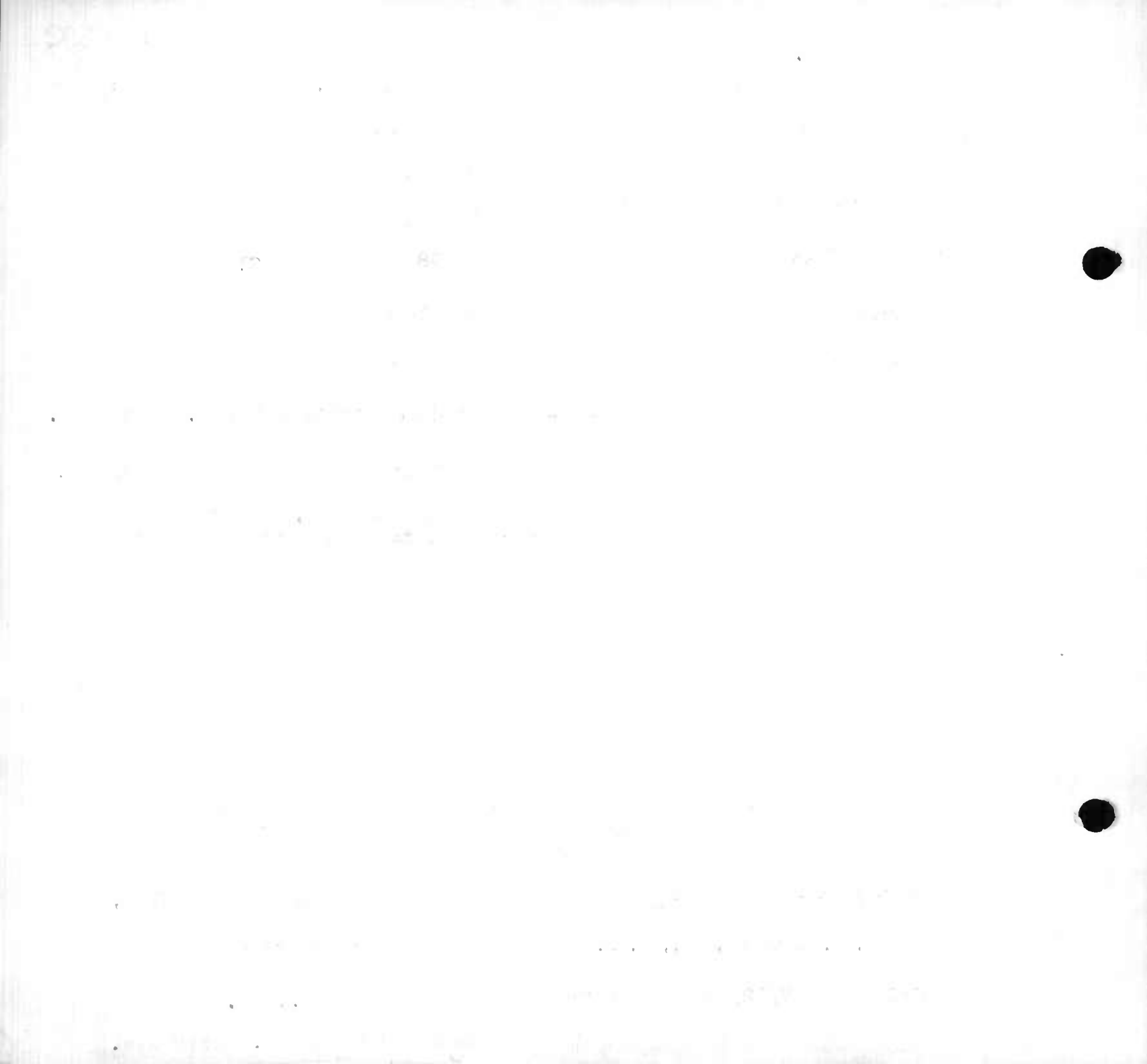
WILLIAM N. F. R. R.

1877

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6992	
BIRTH NO. W-352 1. NAME OF DECEASED (Type or Print) EDWARD WHITING		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> July 8, 1969 9:35 P </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> A. STATE Maryland </div> <div style="width: 40%;"> B. COUNTY 1001 </div> </div> C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2/2/98		9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Edgar Whiting		14. MOTHER'S MAIDEN NAME Ida Boyd			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 088-03-0404		17. INFORMANT Mildred Williams 745 E. Preston St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold; margin-top: 10px;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF: Unknown pulmonary disease, probably primary or metastatic cancer (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. unk	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) was present attended the deceased from July 4 19 69 to July 8 19 69 that (I) last last saw the deceased alive on July 8 19 69 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death.					
23A. SIGNATURE N. F. Adkinson, Jr.				23B. DATE SIGNED July 8, 1969	
23C. PHYSICIAN'S NAME (Type) N. F. Adkinson, Jr., M. D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/69		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm C March 928 E. North Ave.			



1. NAME OF DECEASED (Type or Print) JOSEPH OLIVER KNOWLAND		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1614 W. Lanvale St.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 10, 1969 9:10 a.m.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 4-10-23		10. AGE (In years lost birthday) 46	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Herbert Knowland Sr		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Mamie Robinson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII	
17. SOCIAL SECURITY NO. 215-12-2751		18. INFORMANT Herbert Knowland Jr 1614 W. Lanvale St	
19. CAUSE OF DEATH 486 X 1 Y 303.2		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Bilateral pneumonitis DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) Chronic alcoholism	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Partial			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/69	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

4-10-83

North Carolina

Herbert Knowland Sr

Memie Robinson

Year 1981

218-18-2751 Sergeant Knowland Jr 1914 - 1981

Porter 1/14/80 Arthur H. Park 1910 - 1980

in C. Lynch 222 E. North Ave.

1

P 620 69 6894 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 6994

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OLIVER PIERCE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 7 1969 7:30 p.m.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9-12-97		10. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurateur		14B. KIND OF BUSINESS OR INDUSTRY Self-employed	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Howard F. Pierce		15. MOTHER'S MAIDEN NAME Albertie Freeman	
18. INFORMANT Mrs. Dorothy M. Pierce		ADDRESS 1632 Pennsylvania Ave.	

19. CAUSE OF DEATH
Hypertensive cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION
7-12-69

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
Werner H. Spitz M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner
Herbert E. Nutter

DATE SIGNED
July 8, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)
Burial

24B. DATE
7-15-69

24C. NAME OF CEMETERY OR CREMATORY
Eden Cemetery

24D. LOCATION (City, town, or county) (State)
Collingdale, Pennsylvania

25A. DATE REC'D BY HEALTH DEPT.
JUL 11 1969

25B. NAME OF REGISTRAR
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR
Herbert E. Nutter

ADDRESS
3035 W. North Ave

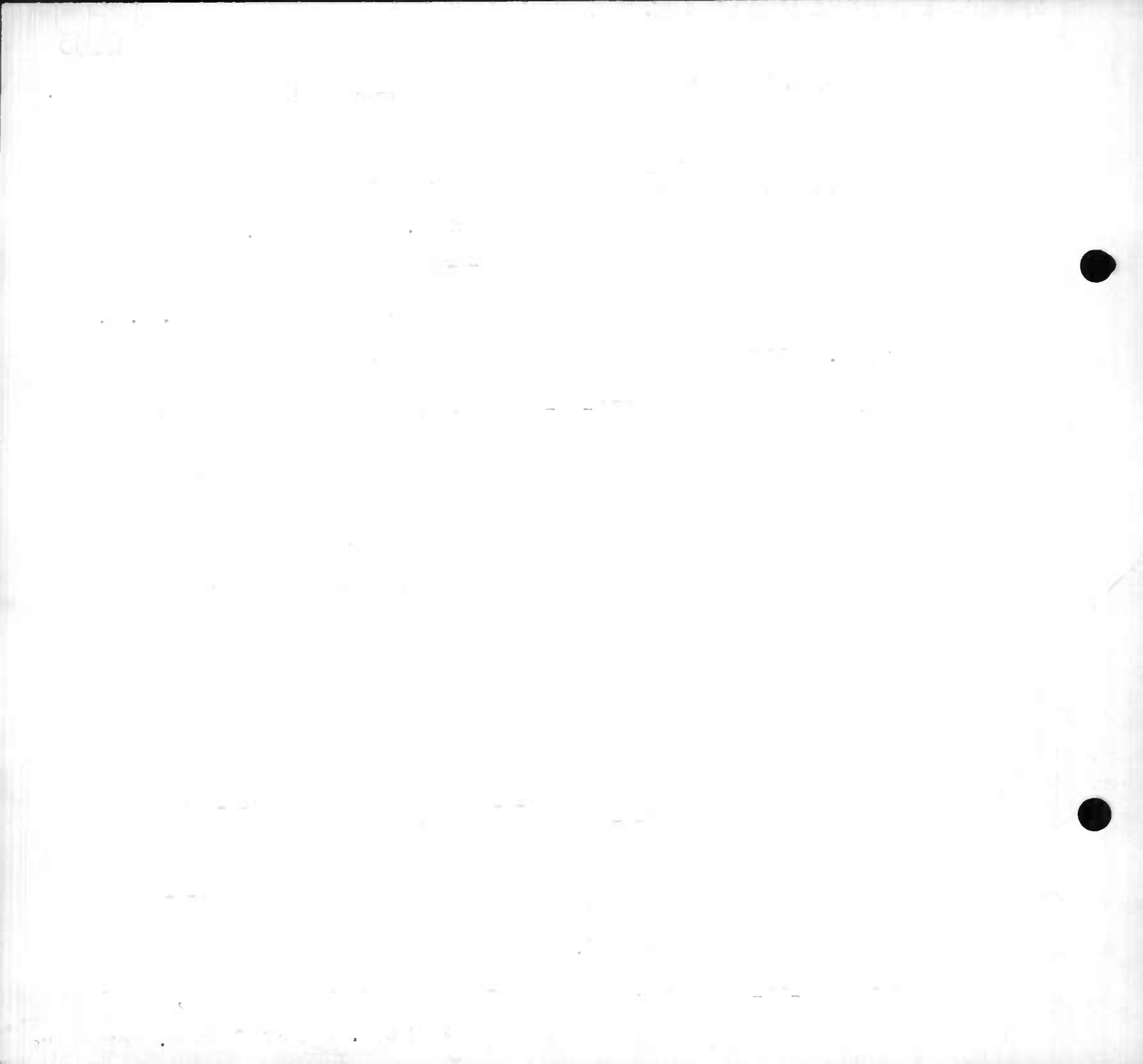
VS 151-REV. 1/1/68

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

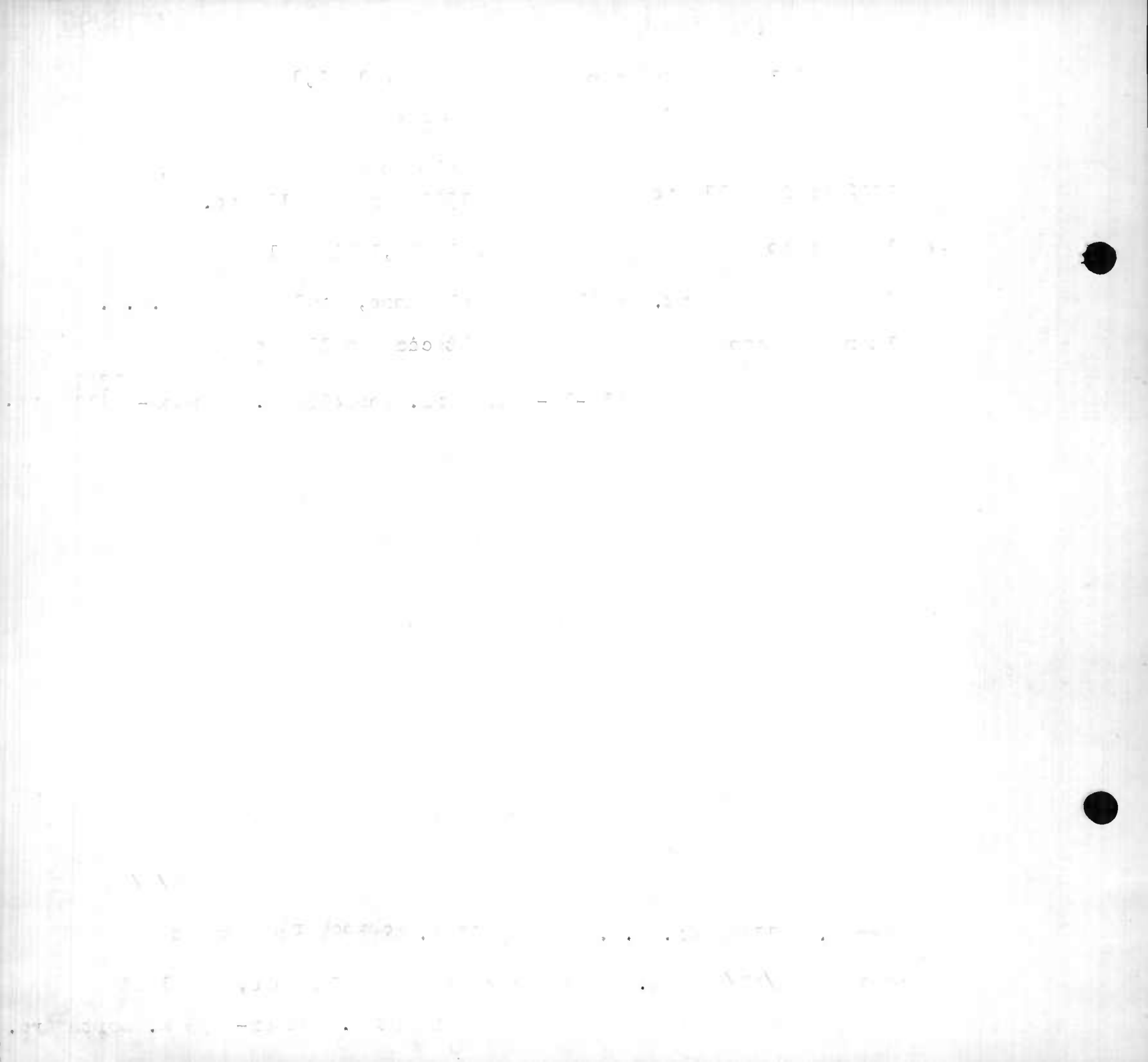
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 6995</u>
BIRTH NO. <u>H-620</u>		69 6995 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Harris, Mathilda</u>		2. DATE AND HOUR OF DEATH <u>7-7-69 8:50</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> Provident Hospital 1514 Divison Street		A. STATE <u>Maryland</u> B. COUNTY <u>1605</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2506 W. Lafayette Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-84</u>	9. AGE (in years last birthday) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. FATHER'S NAME <u>John H. Williams</u>		
14. MOTHER'S MAIDEN NAME <u>Grace Nelson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-07-5841A</u>		17. INFORMANT <u>Miss Daisey Harris</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Diabetic Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Same</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metabolic Acidosis</u> <u>Gen. Carcinomatous</u>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>7-11-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>7-7-69</u> to <u>7-7-1969</u> and that (I) (we) last saw the deceased alive on <u>7-7-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>G. Tengco</u>				23B. DATE SIGNED <u>7-8-69</u>
23C. PHYSICIAN'S NAME (Type) <u>G. TENGCO Md.</u>				23D. ADDRESS <u>1514 Divison Street</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-11-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1969</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u>		
25D. ADDRESS <u>3035 W. North Ave</u>				



FUNERAL DIRECTOR: IMPORTANT

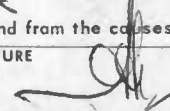
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 6996	
H-385 69 6996		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lily May Hedgemon		July 7, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland 8. COUNTY 1702		
00 1322 Druid Hill Ave			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1322 Druid Hill Ave.		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1887	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter Mason			14. MOTHER'S MAIDEN NAME Stacia Williams		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-18-2246	17. INFORMANT Mrs. Cornelia D. Wharton-Druid Ave.		
18. 410.91-230.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			(A) IMMEDIATE CAUSE Coronary DUE TO, OR AS A CONSEQUENCE OF: (B) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1968 to July 7 1969 , that (I) (we) last saw the deceased alive on July 7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James S. Jullian Jr. M.D.				23B. DATE SIGNED 7/8/69	
23C. PHYSICIAN'S NAME (Type) James S. Jullian Jr. M.D.				23D. ADDRESS 511 N. Schroeder Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.	



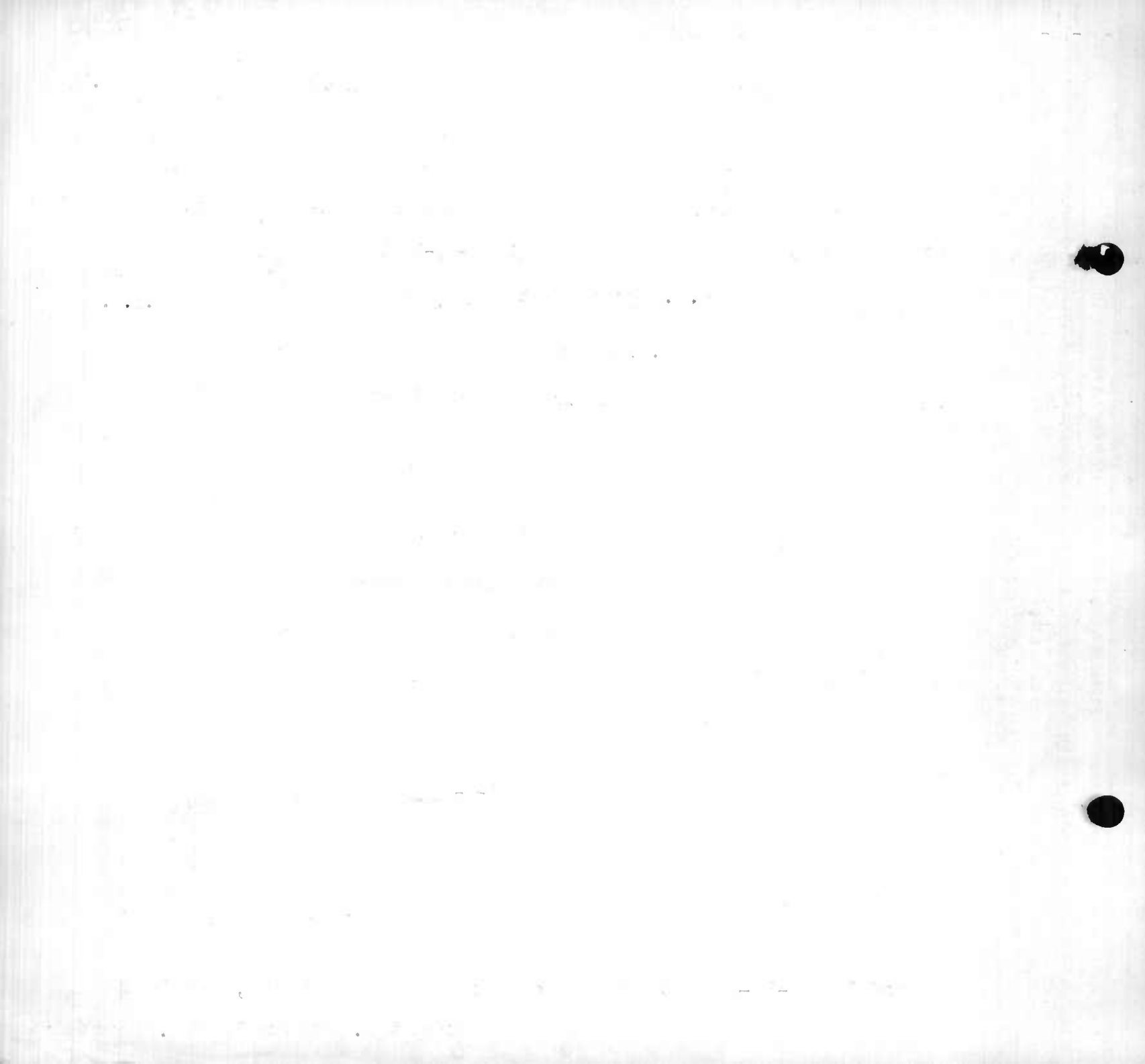
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6997
G-300		69 6997		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WILLIAM GOODE			2. DATE AND HOUR OF DEATH 7.6.69 7-40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 46 Lutheran Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE 2551 Arunah Ave B. COUNTY 1605		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital			C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2551 Arunah Ave		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22 02		9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Barber	11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Will Goode			14. MOTHER'S MAIDEN NAME Mary Sherman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 34 8809	17. INFORMANT ADDRESS A Mamie Goode 2551 Arunah Ave.		
18. 1950 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma Abdomen (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION ○	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 16 1969 to July 6 1969 , that (I) (we) last saw the deceased alive on July 5 1969 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 7/6/1969		23C. PHYSICIAN'S NAME (Type) AHSAN S. KHAN
23D. ADDRESS DEGREE			23E. ADDRESS DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-10-69	24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Gaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Ave	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 69 6998				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 6998	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) JOHNSON, WHITEFIELD				2. DATE AND HOUR OF DEATH 7/8/1969 10.31 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1604			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male				6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photostat Operator				10B. KIND OF BUSINESS OR INDUSTRY U.S. Government Pentagon		8. DATE OF BIRTH 5-17-1911	
13. FATHER'S NAME Clifton O. Johnson				14. MOTHER'S MAIDEN NAME Gertrude Thomas		9. AGE (In years last birthday) 58 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-07-2750		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT Records: BCH-4940 Eastern Avenue				ADDRESS 21224		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF:				6 min			
(B) Myocardial Anoxia DUE TO, OR AS A CONSEQUENCE OF:				12 hrs			
(C) Aspiration Pneumonia				3 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Melitus, Atherosclerosis				20 yrs.			
19A. DATE OF OPERATION 7/2/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AK leg amputation		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-6- 19 69 to July 8, 19 69 , that (I) (we) last saw the deceased alive on July 8, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Michael J. Holliday, M.D.				23B. DATE SIGNED 7/8/69			
23C. PHYSICIAN'S NAME (Type) Michael J. Holliday, M.D.				23D. ADDRESS 4940 Eastern Avenue, Baltimore City Hospitals 5900 E. Pratt St., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-69		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 6999
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Ella Hutson</i>		CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Fayette Convalescent Home</i>		2. DATE AND HOUR OF DEATH <i>9 July 69 2:10 P</i> M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>—</i> C. CITY OR TOWN <i>Balt</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1015 Providence St</i>			
5. SEX <i>Female</i>	6. RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5 Sep 88</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maid</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hopkins University</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Jones</i>			14. MOTHER'S MAIDEN NAME <i>Louise Hill</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-30-2837A</i>		17. INFORMANT <i>Virginia P. Jones</i> ADDRESS <i>1015 Providence St</i>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <i>CHF</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>ASVD</i> DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>C. VA (rt. cereb.) Marantic</i>					
19A. DATE OF OPERATION <i>—</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19 June 1969</i> to <i>9 July 1969</i> , that (I) (we) lost <i>saw the deceased alive on</i> <i>9 July 1969</i> and that in (my) (our) opinion death occurred on the date <i>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</i>					
23A. SIGNATURE <i>Frank Fuller</i> M.D. <small>DEGREE</small>				23B. DATE SIGNED <i>9 Jul 69</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>2214 E Fayette St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-14-69</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 11 1969</i> 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> 25C. FUNERAL DIRECTOR <i>Herbert E. Nutter</i> ADDRESS <i>3035 W. North Ave</i>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 7000		CERTIFICATE OF DEATH		69 7000	
1. NAME OF DECEASED (Type or Print) THOMAS TILLMAN.		2. DATE AND HOUR OF DEATH 7/10/69. 7.00 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SIWAH HOSP.		A. STATE MARYLAND.		B. COUNTY 1513	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4009 SPRUCE DRIVE.			
5. SEX MALE	6. RACE W. G. R.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/11	9. AGE (in years last birthday) 58	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kershev South Caro.	
13. FATHER'S NAME Richard		14. MOTHER'S MAIDEN NAME Charlotte			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown.		16. SOCIAL SECURITY NO. 219-01-7085		17. INFORMANT Mr. Nathenil Tillman	
		ADDRESS 4009 Spruce Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) CHRONIC LUNG DISEASE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC LUNG DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/9/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/29 19 69 to 7/10 19 69 that (1) (we) last saw the deceased alive on 7/10 19 69 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. M. V. M. D.		23B. DATE SIGNED 2/10/69		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS		23E. FUNERAL DIRECTOR Morton & Dyett			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-69		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1969			
25B. NAME OF REGISTRAR James E. Barber, M.D.		25C. ADDRESS 1701 Laurens St.			

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